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THE UNIVERSITY OF ALBERTA

# The World of the Bereaved Child

by

Michelle B. Goodman

(C)

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled The World of the Bereaved Child submitted by Michelle B. Goodman in partial fulfilment of the requirements for the degree of Masters of Education in Counselling Psychology.

Supervisor

Date June 9, 1983

In memory of Ricky and Regina whose deaths taught me much about life.

**Abstract**

This thesis explores the nature of childhood bereavement as a basis for determining how children might be helped to endure and emerge from bereavement psychologically healthy. Often parents are too emotionally laden with their own grief to assist children with theirs. The author's personal position and working hypothesis, as substantiated by the current literature, is that children who present in therapy as having difficulty coping can be helped by the counsellor/therapist to emerge conceptually, emotionally and psychologically more mature from bereavement. Based on a review of the literature and her experience with children in therapy, the author proposes an existential psychotherapy model as one option for those who work in the area of childhood bereavement. The model, entitled PCP--play, confront, promote--is essentially an application of crisis and positive disintegration theories to bereaved children and psychotherapy. It is a "spiralling developmental" model; each of its three phases recurs throughout and beyond the therapeutic process. The four therapeutic goals which underly this model are: *exploring* the child's bereaved world; *entering* and *remaining within* the child's bereaved world; *encouraging* the expression of grief; and, *facilitating* hope and acceptance through synthesis. Various procedures are presented which can be used by the bereavement counsellor/therapist to attain these four goals. Creative adaptations of established psychotherapeutic techniques are presented via transcribed excerpts from actual therapy sessions with two bereaved children. The thesis concludes with recommendations for long-term, longitudinal, comparative and phenomenological research to strengthen the foundation for the working through of children's grief in therapeutic settings.

## Prologue

I just happened to meet Allison, the mother of Karen, a young client of mine, in a local shopping mall. Karen had missed our last session and I made several unsuccessful attempts at making contact by phone. The "not in service" recording still rings in my mind as an ominous reminder; at the time I suspected that it might be a forboding message. As we sat down for coffee, I sensed a certain distance in her manner and tension in her voice. She calmly and collectedly blurted out: "Oh, haven't you heard? Our house burnt down, Ricky (Karen's four-year old brother) is dead." I was unable to hide my shock. My initial reaction was disbelief. "His funeral was on Wednesday," she continued. I collected myself enough to offer my condolences and some support. I made arrangements to see Karen three days later.

A million questions raced through my mind. How would I approach the subject of death with eight-year old Karen...or should I? How could I talk solemnly with this child whom I teased playfully a week previously? Would I pacify her with with sugar-coated tales? What lay ahead was an unexpected opportunity for me as a counsellor to expand upon my existential framework for working with children. What lay ahead for Karen was a chance to grow from a traumatic crisis, while I vicariously explored this foreign territory with her. Was it possible that children, too, could grow from accidental crises? If they could, I certainly wanted to afford Karen the opportunity.

As Karen's unique reactions to her brother's death unfolded, I became interested in children's thoughts and feelings toward death. I was curious to know what psychologists had to say about children's cognitive and affective responses to death. Moreover, as Karen began to endure and surmount her traumatic loss, I was reminded of crisis theory and wondered about its applicability to children. Could there be anything positive for a child, in such a traumatic experience as death?

Relying upon my experience with children, both in and out of therapy, I began working through Karen's bereavement together with her in therapy. After seeing her in therapy for three months, it was evident that through confronting

and working through her feelings and thoughts surrounding her brother's death, she was now able to approach life with renewed vigour. What did we do together in therapy that may have facilitated her re-emergence? In reviewing videotapes and case notes of the therapeutic encounters I had shared with Karen and her surviving brother, Jeffrey, I was able to confirm first-hand, what the literature was to consistently reveal. Moreover, in the spontaneity of my "Moustakian-like" counselling, I found that I had inadvertently adhered to the recommendations proposed by researchers and practitioners in the area of bereavement. Furthermore, I discovered that I had used some particularly effective techniques which were successful in encouraging the open expression of feelings and thoughts; the confronting of deep existential issues concerning life, death and mortal anxiety; and the movement onward and forward of a child's conceptual, emotional and psychological development.

Finally, I wanted to share, in thesis form, *The World of the Bereaved Child*, with those who also have an interest in this area--students, parents, professionals--who might find some of my ideas useful.

As I approached the completion of *The World of the Bereaved Child*, I arranged to meet Allison to check on how she and the children were progressing. During the course of our meeting, she shared with me, candidly and objectively, her personal reactions at the the time of Ricky's death. I was deeply moved and impressed with the insight behind her revelations and I asked if she could capture their essence in written form. She shared a very touching poem with me which she had written (see appendix) a few months after Ricky's death--her therapeutic means of working through the grief. Following here are her more recent words in poetry and prose written in response to my request. The poem is a dedication to Karen and Jeffrey; and the story which follows serves as a rationale for my involvement with them in bereavement therapy.

I Listened to Your Pain

I listened to your pain today
pain I share
the stone dropped into the dark water
circles rise and fall
widen
push water up and out
till the black silk enfolds us
covering nose
blackening sight
in suffocating softness
we can only wait
for the water
slowly
to recede

(Allison Coleman, Note 1)

...My first instinct was to protect them from any more pain than was absolutely necessary, but from my own experiences as a child faced with my mother's death, I know that protection which shuts them out hurts most of all. I was terribly bewildered and confused and angry at thirteen, because I did not know how to act or behave with my mother. Did not know if she knew she was dying, was cut off from her physically and had no one with whom I could talk to about it. The immensity of my mother's dying and her pain were things I needed to deal with then, but could not do so alone. Because we children were protected from the knowledge of what was happening until all hope was gone and because our father was very busy

dealing with his own pain all my attendent feelings had to be dealt with many years later.

When Ricky died, the circumstances were different. It was a sudden death and totally unexpected, but I did not want my children to have to deal with their feelings of grief and guilt alone. What I had not realized, however, was that my own emotions would not allow me to be as open as I wanted. For several months I lived in a haze, in which I tried to make contact with the outside world, including the children, only half-heartedly. It was literally impossible for me to share my grief with the children. I could listen to them and give them hugs, and explanations. It is impossible to shield those we love from pain, but most of us try to do it anyways. We cannot bear to add pain to an already unendurable load, especially to the very young. I know the children were aware, and bewildered, by my grief as I was aware of theirs. I managed to get fairly close to them, but at their instigation, not mine. Children are not nearly so afraid or sensitive about showing their emotions as adults and the younger they are the easier it is to share their sorrow.

Children need to be able to share the catastrophic times with adults, but, from my own experience, I know that it is impossible for parents to be as close to the[ir] children as they want to be. We shy away from showing these feelings and we are overly sensitive to the children's pain. We need outside help at least until the extreme grief is past. (Coleman, Note 3)

**Acknowledgements**

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# I. INTRODUCTION

We make ourselves a place apart
Behind light words that tease and flout.
But oh, the agitated heart
Till someone really finds us out.
'Tis pity if the case requires
(Or so we say) that in the end
We speak the literal to inspire
The understanding of a friend.

But so it is with babes at play
At hide and seek to guard afar.
So all who hide too well away
Must speak and tell us where they are.

Revelation, by Robert Frost

## A. The Nature of the Study

What does the existing literature in the areas of childhood bereavement and children's death awareness suggest for working with children in therapy? Is my current model substantiated by the existing literature as well as by experience with bereaved children in therapy? What are some psychotherapeutic techniques which can facilitate the grieving process in children? These are the basic questions which provide the impetus for this study. It is an investigation into the nature of childhood bereavement and how the therapist/counsellor can help those children who cannot cope adaptively to bereavement. The study is based on the premise that bereavement therapists should focus on a more candid and directive approach for working with these children in therapy. I will present one such approach and attempt to substantiate and integrate it with the current, relevant literature and with my own experience with two bereaved children in therapy.

## B. Need for the Study

We live in a "death-denying" society and this is reflected in death psychology research, which, even today is in its youth. The child's view of death is still a speculative and controversial area in psychology. Basic issues ensue over whether death concerns are part of a child's world, and whether the child learns about death through socialization and actual death experiences.

Moreover, there is an absence of the concept of death in the theories of child development and child psychopathology. It is maintained, however, that dealing with feelings of helplessness and obliteration are major developmental tasks of childhood (Yalom, 1980).

Behavioural research cannot reveal what is innermost, conceptually and emotionally, in children's minds and their hearts. Nonetheless, researchers draw their conclusions based on children's play behaviour, their drawings, and their answers to preplanned questions (Nagy, 1948; Koocher, 1973; Rochlin, 1961). There are few studies, if any, based on long-term involvement in the child's phenomenological experience. "But alongside those thoughts which can be expressed...how many possible thoughts remain unknown so long as we observe the child without talking to him." (Piaget, 1973, p. 18) Furthermore, how can we distinguish a child's play from his or her beliefs without talking and without "being with" him or her over time? "Pure observation [and interpretation] is inadequate for distinguishing belief from romancing." (Piaget, 1973, p. 18) Thus adults who are with children over extended periods of time, parents and therapists, are in an ideal position for actively determining children's thoughts about, and reactons towards, death.

One of the most difficult tasks for adults is helping a child through the crisis of death. Many well-intentioned adults fear that discussing death straightforwardly with children will rob them of their innocence and, therefore, of their childhood. But the child's unfamiliarity with death, the adult's deceptive or withheld explanations and apprehensiveness in talking about the dead person, all combine to erect a barrier of confusion and/or ignorance between children and death, so that working through the grief is denied to him or her (Koocher, 1973; Salladay & Royal, 1981).

Death is a universal phenomenon which eventually effects the lives of all children in one way or another. According to Statistics Canada (1982), in Alberta alone, there were 12,709 deaths in the year 1980. In Canada, one of every 1515 children, ages five through nine, dies each year (Statistics Canada, 1982). Mortality statistics indicate that, by the age of eighteen, one child in twenty will

have lost a parent by death, and in a school of six-hundred students, one child can be expected to die every other year, affecting the lives of the child's friends and classroom peers (Atkinson, 1980). Add to these statistics the deaths of school personnel, extended family members, pets, fatal traffic accidents, wars and violence constantly depicted in the media and it becomes impossible to believe that children can be protected from death.

Adults, it appears, impose their own needs for denial and repression of the inevitability of death onto children. It might be adaptive to deny death in some instances, but denial with the child for whom death is an imminent reality is harmful. Lasting depression often plagues the bereaved child who does not finally express grief. Such depression can have many immediate manifestations such as academic failure, somatic complications, death fantasies, delinquency, withdrawal, fear of being alone, and unwillingness to make friends (Bendiksen & Fulton, 1976; Bernstein, 1977; Greenberg, 1977). There has been some indication that unresolved grief in childhood leads to higher rates of major illness and emotional distress in adulthood (Beck, Sethi & Tuthill, 1965; Bendiksen & Fulton, 1976; Brown, 1961; Greer, 1966).

The overwhelming consistent recommendation by professionals is that children can and should be confronted with the reality of their death experience. Moreover, general guidelines are provided for parents on how this should be done (Greenberg, 1975; Grollman, 1969; Kastenbaum, 1977; Koch, 1977, for example). However, when the parent's own grief reaction is severe or if the child's reactions appear psychopathological, the child is best referred to a professional.

Attention in the literature has been given to several grief process theories and to basic suggestions for grief work, but not to appropriate psychotherapeutic techniques nor on a specific psychotherapy framework. The emphasis needs to be on how the professional counsellor/therapist can use knowledge of grief process and psychotherapy to help the bereaved child. This thesis is an attempt to propose one such application using an existential framework.

**C. Statement of Purpose**

The purposes of the study are:

1. To present a model for working with bereaved children in therapy which is based on:
   a. crisis theory;
   b. established psychotherapy models, especially existential child psychotherapy;
   c. existential presuppositions, especially the existential perspective on death;
   d. my experience with children both in and out of therapy; and,
   e. my current and childhood conceptions of and reactions toward death.
2. To substantiate and integrate the model with:
   a. the literature in the area of childhood bereavement and children's death awareness (conceptions and reactions);
   b. the guildelines and recommendations for helping children cope offered by professionals in the area of bereavement; and
   c. my own "lived" experience with two bereaved children in therapy;
3. To share some of my creative adaptations of established psychotherapeutic techniques with those working with bereaved children in therapy.

**D. General Overview**

My goal in this study is to delineate a model of bereavement counselling which has arisen with and from experience. Existential phenomenological psychology is that discipline which seeks to explicate human experience and human behaviour as revealed through descriptive techniques including disciplined reflection (Valle & King, 1978). Essentially this thesis is phenomenological in that it entails examining phenomena, childhood bereavement and bereavement counselling, as they are actually lived and experienced (Husserl, 1970). By reflecting upon videotapes of my counselling sessions with two bereaved children, and by describing exactly what I "see" myself doing with them, I will elucidate the phenomena of childhood bereavement and bereavement counselling

with children.

This thesis may serve as a handbook for those counsellors and therapists who find themselves needing a general background for their work with bereaved children and/or some constructive ideas to use in therapy. If the chapters are read successively, the thesis presents: a review of the current literature related to children, death and existential child psychotherapy; a model which incorporates issues which have been both addressed and unaddressed in the literature to date; an elaboration of the model through transcribed excerpts of therapy sessions and some technical applications of the model; and some general conclusions with implications for counselling and research.

To experience the evolution of this thesis, the unfolding of the phenomena, and the rebirth of a model, the thesis can be read in the following order--starting with chapter four and proceeding to chapters three, two and ending with chapter five.

Chapter four consists of transcribed excerpts from actual counselling sessions with two bereaved children in therapy. In reviewing these excerpts it becomes apparent that some of the techniques used, actually seem to carry forth the grieving process for these children. I elaborate upon these techniques and make some recommendations for their application.

In chapter three, I present my model and its assumptions. These assumptions are substantiated by the literature review, chapter two, and by my experiences as outlined in chapter four. In chapter five, the discussion, I include an integration and synthesis of chapters two through four, and conclude with the limitations and implications of the study.

Colaizzi (1978), a phenomenological psychologist, contends that "All human research, particularly psychological research, is a mode of existential therapy." The following study is based on the assumption that the reverse is also true. That is, all existential therapy is a form of human research:

> Genuinely human research, into any phenomenon whatsoever, passes beyond research in its limited sense and occasions existential insight. This is nothing other than therapy. (Colaizzi, 1978, p. 69)

The existential therapist draws in the totality of the human person (e.g.,

perceptions, cognitions, emotions, attitudes, experiences, patterns, styles and content of behavior); phenomenological research, therefore, as a mode of existential therapy maintains that any particular phenomenon should shed light on the totality of the human situation (Colaizzi, 1978). "It is clear that psychotherapy is an applied art and the psychotherapist an applied scientist (Strupp, 1968, p. 16)."

## II. LITERATURE REVIEW

The literature review is organized into eight major sections. The first three examine material related to children and death: (a) children's conceptualizations and awareness of death, (b) children's reactions to death, (c) helping children cope with death, within various theoretical and atheoretical frameworks. The next four sections focus on children and death within an existential framework: (d) crises as facilitators of growth for children as well as adults, (e) the existentialist's perspective on death, (f) the existential concerns of children, (g) existential child psychotherapy. This chapter concludes with a synthesis of all the literature reviewed.

### A. Children and Death

#### Conceptualizations and Awareness of Death

> The subject of this investigation--one of the most important but also one of the most difficult in child psychology is as follows: what conceptions of the world does the child naturally form at the different stages of development? (Piaget, 1973, p. 13)

During the evolution of psychoanalysis, little was known about the development of cognitive abilities and therefore their role in shaping a child's death attitude was minimized. Over the decades, however, due to a deluge of systematic studies in the areas of cognitive and social psychology, we have been provided with reliable models of cognitive (Piaget) and socio-cultural development (Erikson) upon which to base death conceptions research. Today, even traditionally psychoanalytic psychologists are dispensing with the intangible concepts of "psychic energy" and "drive" and are "joining ranks" with cognitive psychologists (Bowlby, 1980; Lifton, 1981). Thus psychologists are formulating new theoretical concepts of death and loss based on the more contemporary research findings. Before elaborating on two predominating models, the cognitive-developmental and the socio-cultural, the classical psychoanalytic model will be reviewed briefly.

Psychoanalytic Model

Freud's instinctual model required him to conceptualize both idea and affective state as subordinate to physio-mechanical energic forces. He, therefore, more or less dismissed death in a conceptual sense. He asserted that since we never experience our own death, it is impossible to conceive of death as anything but an instinct.

> Our own death is indeed unimaginable, and whenever we make the attempt to imagine it we can perceive that we really survive as spectators. Hence the psycho-analytic school could venture on the assertion that at the bottom no one believes in his own death, or to put the same thing in another way, in the unconscious every one of us is convinced of his own immortality. (Freud, 1915/1939, p. 15)

To Freud death is "unimaginable" and psychically unavailable. The concept of death instinct, however, seems to contradict biological principles, and furthermore, there has been no biological observations to support it.

Freud maintained that death was alien to children. Only children who have seen the suffering that precedes death can differentiate death from other ways absence might be brought about e.g., distance, divorce (Freud, 1900/1938). To most children death was just like "being gone." Essentially Freud emphasized the inability to accept or understand personal finitude. Maurer (1966), a more contemporary psychoanalyst, believes that there is ample support from childhood behaviours ("night terrors," their fascination with the game "peek-a-boo" and with making objects disappear and reappear, and "separation anxiety") for the assumption that children are able to differentiate between being and non-being which is an initial adaptation to understanding personal finitude. The cognitive-developmental model describes the development of the child's understanding of personal finitude.

Cognitive-Developmental Model

There has been an immense amount of support in the literature for an age-graded developmental model. According to this model, children's conceptions of death adhere closely to the Piagetian cognitive-developmental model which states that a child's level of reasoning is dependent upon maturation and learning. Children pass through sensorimotor, pre-, concrete and formal operational stages as their mental structures mature and as they interact with

their environment. There is this same developmental progression in their thoughts about death, which too, depend upon cognitive maturation and learning (Kane, 1979; Koocher, 1973; Stillion & Wass, 1980).

Nagy (1948), in her foundational study in the area, used interviews, children's written stories and drawings to explore the conceptualization of death in 348 Hungarian children aged three to ten years. Nagy (1948) concluded that there are three age-related stages in children's understandings of death. According to Kane (1979), Koocher (1973), and Stillion and Wass (1980), these stages are similar to Piagetian stages.

The first stage, which encompasses the age ranges of three to five years (two to seven years according to Stillion & Wass, three to six years according to Kane), resembles Piaget's preoperational stage in that it reflects the egocentric minds and the magical thinking of preschool children. At this stage, children know that they must eat, sleep and breathe, so they attribute life processes and consciousness to the dead (Nagy, 1948). Nagy (1948) cites one preschooler as saying: "The dead close their eyes because sand gets into them" (p. 7). To these children death is defined in terms of structure; it is real, there is separation and the deceased person is temporarily immobile (Kane, 1979). Temporal orientation at this stage is "now"--death is realized in terms of the present and the immediate.

In Rochlin's (1961) study, one researcher asked a five-year-old: "But surely you don't think the dead person still sees?" The child answered, "No, they can't see, poor things. It's dark in those coffins. But then at night, when they come outside, they can see then. But not so well." (p. 137) Thus while preschoolers know that dead persons are buried underground, they view death as a kind of sleep or temporary state. The magical thinking which characterizes their cognitive development is reinforced by the way death is portrayed for them in fairy tales (Snow White and Sleeping Beauty, for example) and also by their own sleep which is temporary.

Anthony (1940) postulated an early developmental stage (ages three and four) during which time the child, restricted by limited speech, has no idea of

death. She found that it was not until age five that children developed a limited or erroneous concept of death. Steiner (1965) reported that four and five-year-olds denied thoughts of death but did admit to playing and dreaming about death. In a more recent effort, Swain (1979) in a study of 120 children under five, found that they tended to view death as reversible or escapable rather than inevitable and personally applicable. Prior to the age of five, it appears as though children categorically deny the reality and irreversibility of death (Nagy, 1948; Safier, 1964).

The second stage, ages five through eight (seven to nine according to Kane) is comparable to the stage Piaget describes as the "age of the scientist" or concrete operations. The child is full of curiosity about the workings of the world and is sorting out impressions, object categorizations and is discovering laws of cause and effect. With their growing awareness of the way the world operates they now recognize death as final (Nagy, 1948; Steiner, 1967). Both Nagy's and Steiner's "middle-aged" children viewed death as personally remote and external. Nagy's children frequently personified death as a skeleton, ghost, or powerful monster. Stillion and Wass (1979) suggest that the personification is an attempt to bring the topic into a more easily understandable cause-effect relationship. Children at this stage believe that "death comes to get you," but if you are fast or clever enough you may escape (Nagy, 1948, p. 5). As children begin stage two thinking, they associate death and obvious dysfunctionality and have ideas such as:

> Dead people can't move, blink their eyes, or work their mouths; they get hungry but can't eat because they can't move their hands, don't eat but do drink, and hear voices but don't answer. (Kane, 1978, p. 70)

During this period children worry about the mutilation of the body (Koocher, 1973) and this is illustrated in poems they write (Arnstein, cited in Lonetto, 1981). In Swain's (1979) study of American children over the age of five, the children did not demonstrate to any significant degree the belief in ghosts or functional capabilities of the dead as cited by Nagy (1948). They did, however, express the belief in either a spiritual life after death or in the total finality of death. Though children at this stage recognize death as final, they see it as

capricious. Swain (1979) found that children from ages five to seven, about the time when they enter school, exhibit the greatest changes in death conceptions, exhibiting less magical thinking and a greater reliance on biological and social reality.

For most children, ages seven or eight provides the turning point for the understanding of the biological and logical essentials related to death (Anthony, 1940). These, however, are not completely assimilated until age nine or older. The child at this second stage has not yet incorporated the ideas that death is inevitable, natural and universal. Children will demonstrate interest and anxiety about funeral and burial rites at this stage.

The third stage of death understanding is characterized by a complex integration of concepts as seen in Piaget's formal operations. According to Nagy (1948) this stage can begin as early as nine years of age (the true formal operations period begins at twelve years). Children at this stage recognize death as inescapable and universal (Nagy, 1948). They view it as personally applicable; a natural, internal destruction process that will happen to everyone including themselves. There is a shift which occurs here where death is seen as being determined by internal forces instead of being taken away by powerful outside forces.

In a study by Childers and Wimmer (1971), eleven percent of the four-year-olds recognized death as universal but by age nine, one hundred percent of the children did. Sixty-three percent of the ten-year-olds, as compared to thirty-three percent of the four-year-olds recognized death as irrevocable. Alexander and Adlerstein (1958), Caprio (1950), Hall (1922), Harrison, Davenport and McDermott (1967), Portz (1965), Schilder and Wechsler (1934), (1965), Steiner (1965), Von Hug Hellmuth (1965), using various methodological procedures, provide further support for children's awareness of death as universal and irrevocable at this developmental stage.

Formal operational children can recognize reality, and also speculate in a somewhat uncommitted fashion. "Ultimately they can consider the existential quality of life and death." (Kane, 1978, p. 71)

Death Conceptions and Death Experiences

Kane (1978) has found experiences with death to be important in terms of concept development for children six-years of age and younger. When children of this age experience death, they evidence more mature concepts than their inexperienced age peers. Children aged seven through twelve years, on the other hand, manifest the same maturity of concept whether they experienced death or not (Kane, 1978). Swain (1979) found children five to seven to exhibit the greatest changes in death conceptions. Children at this age have greater reliability on biological and social reality which would indicate that their conceptions of death would be influenced by actual experiences with it. Thus bereaved children, have an early conceptual edge on their age peers which disappears as the other children just naturally mature. Further research is needed to explicate and validate these findings.

Summary

Results derived from retrospective questionnaires (Scott, 1896; Hall, 1922; Caprio, 1950), interviews (Anthony, 1940; Nagy, 1948; Steiner, 1965; and Swain, 1979), observations of play (Rochlin, 1967), and controlled experiments (Alexander and Adlerstein, 1958) agree to a certain extent with the notion that the child's conception of death moves linearly from a state of non-awareness, through an intermediate stage where death is externalized and/or personified in many forms, to one of an appreciation of death as universal. This agreement is limited to the description of developmental stages of attitudes toward death and there is still considerable disagreement in terms of explanations of the characteristic responses at specific age and maturational levels (the previously outlined discrepant views of Swain, Nagy and Steiner, of the preoperational child, for example).

The *Nature-Nurture* of Children's Death Conceptions

Some researchers (Cook, 1973; Childers & Wimmer, 1971; Jackson, 1965; Kliman, 1968; Safier, 1964; Stein, 1955; Steiner, 1965; Stillion & Wass, 1980; Zeligs, 1974) claim to have duplicated Nagy's findings and consequently support the universal application of her model to children of all cultures. They

argue that there are discrepancies between the adult and child views of death which may be attributed to maturity and age. Other academics (Grollman, 1967; McIntire, Angle & Struempler, 1972; Morissey, 1965; Plank & Plank, 1978; Rochlin, 1967; Swain, 1979), however, report that their data can be interpreted as support for conceptualizations that contradict the age-graded developmental model and emphasize other variables (for example, social and cultural background and experiences) over age.

Multi-faceted Model: Social and Cultural Experiences

Myra Bluebond-Langner (1977) inquires:

> Do children's concepts of death develop with respect to age, with newer, more "scientific" explanations replacing "fantasy" explanations? Or, are all views of death present at all times in one's development; and does the particular account of death one gives at any one time reflect not so much age as intellectual and social experiences and psychological concerns and circumstances at the time the question is asked; and does the forum of such expression even belie the conception? (p. 51)

Bluebond-Langner (1977) formulated a multi-faceted model as an alternative to the age-graded developmental while working with terminally ill children. She found that these children came to know that they were dying in terms that were thought only to be possible in children over nine. Their views of death and dying, as indicated by their behaviour, are a reflection of their experiences, concerns, and circumstances at the time of their illness. To these children (regardless of their chronological age or cognitive-developmental stage) death and dying were viewed as mutilating experiences, which incur separation and loss of identity. To them, it is a final, irreversible, fact of life.

Bluebond-Langner (1977) proposes that several views of death (death as: separation, result of intervention by a supernatural being, an irreversible biological process) are present at all stages in a child's development. The particular view of death that a child presents at any one time reflects his or her social, cultural, psychological, and intellectual experiences and concerns at the time of the death interaction. She argues that five-year olds speak of death as separation because most of their years are spent in first separations (leaving home for school; parents leaving for work). Seven-year-olds, with their newly developed sense of individuality and independence, view death as a remote

possibility as far as they themselves are concerned. Children age nine are exposed to science in school and are called upon to give scientific explanations. According to Bluebond-Langner (1977), what has led previous experimenters astray (namely Nagy) is their tendency to equate what children say with what they think; to allow what is on the forefront of their minds to stand for all that is in their heads.

While systematic study following Bluebond-Langner's model has not yet been undertaken, there is strong support from the work of Grollman (1967), Kastenbaum and Aisenberg (1972), McIntire and his colleagues (1972), and Rochlin (1967), to warrant consideration of social and cultural experiences as influential in the development of a child's view of death. Her view, in accordance with the views of Kane (1978) and Swain (1979), supports a "growth through crisis" approach which is proposed in this thesis as a working hypothesis. In other words, depending on contextual factors, children who have a death encounter tend to develop faster psychologically, emotionally and conceptually from this experience than they would have without it.

Summary

Freud minimized the role of cognition and social development in shaping a child's view of death. Recent studies, however, have investigated the relative influence of cognitive-developmental and socio-cultural factors in the development of death cognitions. Although there is substantial support in the literature for the cognitive-developmental age-graded approach to children's death conceptions, development involves more than maturation; it results from an interaction of biological readiness with environmental factors. Life experiences, levels of intellectual and emotional functioning, religiosity, family attitudes, and values, self-concept, and many other yet unexamined factors all likely play a part in each child's individual attainment of the meaning of death.

**Children's Reactions to Death**

> We are afraid. The fear of our own feelings--and of our children's as an echo of what ours may have been--keeps us from doing the things we most want. How do we know how children feel? (Baruch, 19660 p. 31)

Children share in a variety of responses to the loss of a loved one depending on their previous experiences, the instructive preparation they have been provided with, and/or the resourcefulness of those around them (Furman, 1974). While some may come to accept death as a natural and non-frightening phenomenon (Dunton 1970; Furman, 1974), others may be emotionally and conceptually unprepared to deal with the reality and finality of such a loss (Salladay & Royal, 1981). Grief is the emotional response to bereavement. It is how the person's total being has been affected by the loss. Grief is so common and so painful that it is of primary importance for those who wish to understand and help the bereaved. It is also important for anyone working with bereaved children, to be able to differentiate between natural and abnormal grief reactions.

There does not appear to be an emphasis on the theoretical foundations in the death reactions literature aside from some object relations (psychoanalytic) hypotheses. Therefore, there will be no direct reference made to psychological theory in this section. The grieving process is outlined and then some child-specific responses to death are presented. Pathology, resulting from unresolved grief, will be addressed as will various factors which influence the nature of grief expression. Two key responses, guilt and fear, will then be elaborated upon.

The Grieving Process

In an attempt to outline and explicate the grieving process, several practitioners have developed stage theories. Oates (1954) has presented a very comprehensive six-phase theory of how the grieving process is experienced by the bereaved individual. The stages are not necessarily distinct and may overlap somewhat. *The shocking blow of the loss-in-itself* is the first stage, where the relentless external world enters the subjective world of the survivor. Life continues on as if there has been no change, and there is temporarily no

experience of anxiety. *The numbing effect of shock*, equivalent to the freezing effect of a local anesthetic, is the second phase. The survivor gradually begins to face the reality of the loss as the shock wears off. *The struggle between fantasy and reality* is the third phase, where the individual acts as though the deceased is still alive. Oates gives the example of a seven-year-old child whose mother had died a year prior to an incident in which he was wrestling playfully with his dad. He exclaimed: "Mommy, mommy, make daddy quit" (p. 53). When the fantasy eventually disappears there is a *breakthrough and flooding of grief*. The pain at this stage is even more intense in cases where there was interfamilial conflict before the family member died. The fifth phase is characterized by a *selective memory and stabbing pain*. After several recurring waves of grief, it levels off until is is re-awakened by stimuli associated with the deceased. This remembrance elicits a stabbing pain. "Bereavement dreams" may occur throughout the day and night laden with erotic and hostile material. The final phase of Oates' stage theory involves the *acceptance of the loss and the reaffirmation of life itself*. He describes it as the individual "first rejecting life in face of death and then accepting death in face of life..." (p. 55). This is done by intergrating the image of the lost one into the bereaved person's concept of self.

Westburg (1961) proposed a ten stage-theory which involves the following phases, not necessarily occurring in order: shock, emotional release, symptoms of physical distress, inability to concentrate on anything but the lost person, depression, guilt, hostility, unwillingness to go about normal behaviour, realization that withdrawal from life is unrealistic, and readjustment to reality. At this point, though the major grief work has been done, the survivor will experience shorter cycles in which some of the above stages will be re-exprienced, but with less intensity (Westburg, 1961).

Kubler-Ross (1969), the most renowned stage theorist, has described the dying and grieving processes in stages of: denial and isolation, anger, bargaining, depression, acceptance, and hope. Other stage theories, similar in content and scope, are proposed by Bowlby (1974), Hodge (1972) and Lindemann (1944).

Child-Specific Reactions

Children, with their immature conceptual and emotional development, express their grief in ways that may not be recognized by adults. A child's repetitive play, symbolically acting out the death trauma, constant searching for the deceased, or apparent indifference and nonchalance all may be misunderstood (Atkinson, 1980; Dunton, 1970; Mills, Reisler, Robinson & Vermilye, 1976). The child's immediate return to play may appear to be callous and uncaring, but in reality is a "return to the familiar to allow time to assimilate and accept what is horrible, new and unfamiliar" (Furman, 1970, p. 71). A child may persistently and curiously question a surviving parent as to why the other one died. Such a response may represent the child's attempt to clear up his or her own confusion and guilt regarding the death (Irwin & Weston, 1963; Dunton, 1970; Plank & Plank, 1978).

Some children may demonstrate a strong attachment to objects which represent and remind them of the deceased, such as photographs, a particular article of clothing, or perhaps even a mannerism. These attachments may be constructively healthy if they signify a comfort and source of happy memories (Greenberg, 1975; Koch, 1977); or they may serve as a detriment if they cause the child to cement his or her identity too permanently with the deceased (Koch, 1977).

Furman (1974) cautions adults not to assume that the child feels nothing just because the adult forms of grief are absent. The most dramatic influence of the death may not necessarily be the loss of a particular person, but rather the symbolism of object loss, the sense of abandonment, and the longing for the companionship and joy which were associated with the deceased (Fassler, 1978). These concepts are especially significant for young children who have lost a parent, as most frequently a child's love and sense of security are heavily invested in his or her parents.

The separation by death from a parent or even a sibling represents to the child a major threat to self, and engenders feelings of helplessness and frustration (Alexander & Adlerstein, 1958; Salladay & Royal, 1981). Closely

associated with these feelings is a sense of ambiguity surrounding any intimate attachment. With the death of a parent or sibling, children struggle with a breakdown in trust and with unconscious feelings of responsibility for the crisis. These feelings lead to guilt and hostility which are often manifested in the form of rebellious behaviour (Blank, 1975).

Pathological Reactions

When grief does not accompany loss, deeper problems sometimes surface immediately or years following the loss. The *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1980) refers to normal grief as "uncomplicated bereavement" and pathological grief as "complicated bereavement" (p. 333). Horowitz (1980) defines pathological grief as:

> ...the intensification of grief to the level where the person is overwhelmed, resorts to maladaptive behaviour, or remains interminably in the state of grief without progression...towards completion....[It] involves processes that do not move progressively toward assimilation or accomodation but, instead, lead to stereotyped repetitions or extensive interruptions of healing. (p. 1157)

Lasting depression often plagues the bereaved child who does not finally express grief. Such depression can have many immediate manifestations such as academic failure, somatic complaints, death fantasies, delinquency, withdrawal, fear of being alone, and unwillingness to make friends (Bendiksen & Fulton, 1976; Bernstein, 1977; Greenberg, 1975).

Although direct causality has not yet been proven, the death of a parent or sibling during childhood has been found to be associated with depression and with higher rates of major illness and emotional distress in adulthood (Beck, Sethi & Tuthill, 1963; Bendiksen & Fulton, 1976; Brown, 1961). In a study by Brown (1961) forty-one percent of a population of 3216 depressed adult patients had lost a parent through death before age fifteen. In a later study by Beck (1963) twenty-seven percent of patients in a highly depressed group reported loss of a parent before the age of sixteen as compared with twelve percent of adults in a non-depressed group. An appreciably larger number of patients in the highly depressed group lost a parent before the age of four. More recent studies by Birtchnell (1973) and Templer (1976) have confirmed these original findings regarding the links between parental death and depression.

Rosenzweig and Bray demonstrated a relationship between adult schizophrenics and loss of a sibling during childhood (cited in Yalom, 1980). It appears that loss of a significant other, is a traumatic psychological event for a child and the earlier the loss occurs, the more potentially devastating the effects can be.

Antecedent, Concurrent and Subsequent Factors

Cain, Fast and Erickson (1964), in reviewing their clinical data, found the determinants of children's response to the death of a sibling to include the following antecedent, concurrent and subsequent factors:

> ...the nature of death; the age and characteristics of the child who died; the child's degree of actual involvement in his sibling's death; the child's pre-existing relationship to the dead sibling; the immediate impact of the death upon the parents; the parents' initial handling of the surviving child; the reactions of the community; the death's impact upon the family structure; the availability to the child and parents of various 'substitutes'; the parents enduring reactions to the child's death; major concurrent stresses upon the child and his or her family; and the developmental level of the surviving child at the time of death, not only psychosexual development, but ego development, with cognitive capacity to understand death. (p. 752)

Not only does the death of a parent take its toll on a child, so does the surviving parent's reactions. Parental grief, for example, carries a definite impact upon a child's reaction to death (Irwin & Weston, 1963; Cain et al., 1964; and Koch, 1977). Parents are accredited, especially by fairly young children as being omnipotent; therefore if the parent denies that the death has really occured or completely avoids the discussion of death, the child may easily follow this cue and enter into a denial phase which may or may not be resolved with time (Koch, 1977). A child may be overwhelmed by a parent's excessive grief which, unless it is given proper explanation, may serve as a source of insecurity and/or guilt due to the child's magical thinking (Irwin & Weston, 1963; Koch, 1977; Salladay & Royal, 1981).

Fear of Death

"The worst sorrows in life are not in its losses and misfortunes but in its fears (A.C. Benson)."

The child's affective response to death that has been most often studied is the *fear* of death. Children who have experienced separations and prolonged insecurity in the past are more susceptible to developing fear about the

possible death of a parent (Mitchell, 1967; Salladay & Royal, 1981). Children who have lost a parent, typically fear the loss of the other. The death of a sibling or parent can reactivate unresolved separation anxieties (Salladay & Royal, 1981). The contributions of Caprio (1950) and Kotsovsky (1939) attempt to find links between the fear of death and emotional influences brought to bear on the child by: funeral and burial rites; parental superstitions about the rites; and, the guilt and disappointment associated with not fulfilling one's potential before death. Depending on how these issues are approached, they have the potential to induce unrealistic, neurotic fears in children.

Fear of death has also been associated with fear of loss of self, the ultimate narcissistic fear (Harnik, 1930; Monsour, 1960). Fear of threats imposed by fantasy creatures such as monsters and ghosts (personifications of the deceased) are spurred on by experiences with death (Becker & Bruner, 1931; Caprio, 1950).

Anthony (1940) proposed a view of death which consists of two distinct streams of death-related fear as experienced by children: an anxiety which centers around feelings of aggressive thoughts and actions about retaliation from others; and, a critical type of anxiety derived from feelings of being an independent entity but one that is vulnerable and can be obliterated by external forces. Her conclusions are that, although there is nothing particular to childhood in terms of emotional reactions to death, there are some periods of growth that are characterized by stress and change.

Guilt

Guilt is experienced by most bereaved children and, if it is overwhelming, it may lead to breakdown in communication with others, difficulties in functioning effectively, self-hatred, and general self destruction (Anthony, 1949). Because of magical thinking, beliefs ensue that the child's bad wishes (deriving from jealousy or bad thoughts) are what killed the deceased and that punishment is forthcoming in retaliation (Anthony, 1940; Salladay & Royal, 1981). Cain, Fast and Erikson (1964), in a comprehensive study on sibling survivors, found that guilt was one of the most frequent reactions, sometimes persisting

for as long as five years or more:

> Such children felt responsible for the death, sporadically insisted that it was all their fault, felt they should have died instead of the dead sibling. They insisted they should enjoy nothing and deserved only the worst. Some had suicidal thoughts and impulses...this also being motivated by a wish to join the dead sibling. They mulled over and over the nasty things they had thought, felt or said, to the sibling and became all the guiltier. They also tried to recall the good things they had done, the ways they protected the dead sibling and so on. (p. 743)

Children who have witnessed fatal accidents experience guilt and remorse for their helplessness, especially if another child is involved, and worse, if the child was put in their charge (Cain et al., 1964; Blank, 1975). Other disturbed behaviour patterns found by Cain and his associates (1964) include: trembling, crying, and sadness; fear of doctors and hospitals; and fear that they themselves might die at any time. A few suddenly regressed, seemingly not knowing their ages nor understanding simple cause-and-effect relationships.

Summary

The literature on the reactions of children to the death of a significant other has shown that children manifest disturbances in both their affective and cognitive functioning (Barnes, 1964; Cain, Fast & Erickson, 1964; Furman, 1964; Cain, Cain & Fast, 1966; and Rosenblatt, 1967). This work has tended to point out the need for effective therapeutic interventions for the bereaved and disturbed child. The view as expressed by Rosenblatt (1967) is that the only way we can prevent the emotionally debilitating consequences of death of a family member is to do away with death itself. Experience with death is always followed by grief, but if such grief remains unexpressed, both immediate and long-term emotional and sometimes somatic problems can be expected. Signs of excessive or prolonged grief (i.e., more than two years beyond the death) require the intervention of a professional trained in counselling or psychology.

**Helping Children Cope**

> Give sorrow words; the grief that does not speak
> Whispers the o'erfraught heart and bids it break. (Shakespeare, *Macbeth*, Act 4 Scene 3, line 209)

> Explaining death to a kid
> is not a piece of pie,
> Because you gotta be there to know
> Just how it is to die. (A child's poem cited in Sternberg & Sternberg, 1980, p. 81)

When there is a death in the family, adults, concerned with protecting children from grief, often exclude them from participation in related activities and feelings. Children, however, even preschoolers, have a genuine interest in knowing what death is and have the emotional stamina to survive loss and grief (McConville, 1970; Parness, 1975; Rosenblatt, 1967; Rudolph, 1977). The argument that children should be protected from the harsh realities of life as long as possible is considered fallacious, and in fact is detrimental to their emotional growth (Feifel, 1969). Ginott (1961), a renowned child and adolescent psychologist, claims that:

> A child should not be deprived of his right to grieve and mourn. He should be free to feel sorrow in the loss of someone loved. The child's humanity is deepened, and his character ennobled, when he can lament the end of life and love. (p. 171)

Formanek (1975) suggests that many of the emotional, psychological and relational difficulties children face in successfully resolving grief are correlated with their conceptual framework surrounding the meaning of death. It is important, therefore, that children be given the facts as well as help at the feeling level (Formanek, 1970; Furman, 1970; Ordal, 1980). Ordal (1980) cautions adults not to assume young children can only be dealt with at feeling level. Acceptance of death, he contends, must be both intellectual and emotional. Kastenbaum and Aisenberg (1972) agree:

> ...we might discover that the problem of death is the first vital intellectual challenge to engage the child's mind and, as such, is a prime stimulus to his continued mental development. (p. 15)

The overwhelming consistent recommendation by professionals is for adults to realistically help the child confront and accept death:

> When a death occurs and the child is not told what happened, he may remain shrouded in nameless anxiety. Or he may fill the gap in his knowledge with fearful and confused explanations of his own. He

> may blame himself for the loss and feel separated not only from the dead, but also from the living. (Ginott, 1961, p. 171)

The first step towards this end is to determine where the child stands on his or her pre-existing conceptions of death (Formanek, 1975; Kastenbaum & Aisenberg, 1972; Nagy, 1948; Mills, Reisler, Robinson & Vermilye, 1976). This conception will determine the breadth and depth of explanation which a child may comprehend (Mills et al., 1976). Kolls (1977) concluded from his study that children must deal with the experience in their own way and at their own level. By experiencing the loss of a loved one first hand, a child is given the opportunity to develop feelings of sympathy, compassion, grief and sorrow (Ginott, 1961; Kolls, 1978).

Guidelines for Parents and Professionals

I have compiled the following list of guidelines based on recommendations by professionals who work in the area of bereavement with children. These professionals base their recommendations on philosophical and practical issues as well as on observational and research evidence. The recommendations are designed as general guidelines for parents and professionals working with bereaved children.

1. Sympathize but do not pity. Adults tend to pity children who are experiencing a death crisis and according to Dreikurs (1964) this pity can bring about more harm than the tragic event itself. He explains that by pitying the child adults are indirectly granting permission for indulgence in self-pity. While engrossed in self-pity the child neglects to take responsibility for fulfilling life's tasks and searches aimlessly for someone else to fulfill them. Thus, the child's emotional development is thwarted; the child remains self-centred instead of self-directed and is prevented from reaching outward and from moving onward. Dreikurs (1964) distinguishes between sympathy and pity:

> Sympathy implies "I understand how you feel, how much it hurts or how difficult it is for you. I am sorry about it and will help you overcome the hardships of your situation." Pity implies a rather subtle patronizing superior attitude toward the one being pitied. "You poor thing. I feel so sorry for you. I'll do all I can to make up for what you suffer." Feeling sorry for the "it" which happened is sympathy. Feeling sorry for the "you" to

whom it happened is pity. (p. 247)

Trust, faith and respect for the child requires support for his or her sense of dignity instead of lowering it by encouraging self-pity (Dreikurs, 1964).

2. Encourage discussions which are factual; do not aid in the creation of alternative myths. A child's perceptions of death may be couched in images which lie between fantasy and fact, what Piaget (1973) calls the "mythomania" of the child. Nevertheless, most children have an awareness and sensitivity to which honest, yet simple explanations of death may be directed (Grollman, 1967; Kastenbaum, 1975; Parness, 1975). The literature unanimously cautions against offering explanations which may lead to reality confusion, such as "God reached down and took daddy to heaven" or "Daddy's sleeping." Silence teaches them only that the topic is taboo; it cannot help them to cope with their feelings of loss (Koocher, 1973). Metaphors and taboos have a tendency to confuse the young child and may invoke fears of certain normal activities (sleeping, for example) which require extensive counselling to alleviate once they have been incorporated into the child's attitudinal and belief system (Kubler-Ross, 1969; Salladay & Royal, 1981). Adults should recognize the young child's need for protection against grief and fear of death at the time when it is expressed, but they must be truthful about facts and not use euphemisms which may lead to serious confusions (Ginott, 1961; Rudolph, 1977).

3. Share personal feelings. The adult must be willing to share feelings of grief honestly and in a positive way that communicates faith in the child (Ginott, 1961; Parness, 1975). By sharing in the experiencing of these feelings with adults, the child is provided with modelled behaviours that will serve as reference points for coping with death in later life. Children's abilities to survive emotional crisis are strengthened by the parent, teacher, or counsellor who is able to address with the child the possible conflicts of meaning and to confront paradoxes and problems which put the child's psychological health in jeopardy (Kolls, 1977). Dreikurs

(1964) adds: "In times of crisis, children look to adults for a clue as to how to deal with an unfamiliar situation. They sense our attitude and use it as a guideline." (p. 246) Most authorities agree that it is good that the child see the surviving parent's own honest sorrow and tears; this will help the child express his or her own grief (Freese, 1977; Ginott, 1961; Grollman, 1967).

The child needs to be encouraged to grieve so as to aid in the clarification of confusion and the building of trust (Plank & Plank, 1978). The child needs a "relief valve" by which he or she can ventilate feelings and test the atmosphere of support which remains (Salladay & Royal, 1981).

4. Adults should own their feelings and abide by their own beliefs. Not informing children about death has become part of our general avoidance of crises. This avoidance is bound strongly to the feeling that life (children) can neutralize death. Parents and counsellors must be able to deal with their own fears of death in order to create an atmosphere for telling and coping (Hoffman & Futterman, 1971). The goal of discussion is one of helping them, and ourselves, to live more freely, unrestricted by the death taboo. When a parent acknowledges ambivalent feelings, the child will feel free to do the same (Ginott, 1961; Grollman, 1967). In discussing death, it is important for adults to be true to their own beliefs. If they do not believe in life after death, they should admit to children that they do not know what happens to the person after death (Simpson, 1979). Grollman (1970) advises adults not to express a religious conviction they do not personally believe: Children have built-in radar and quickly detect your inconsistency and deception. Share honest religious convictions, but be prepared for further questions concerning simplistic theological terms. (p. 36)

5. Review specific memories. Allow the child to share his or her pain after a death by reviewing specific memories of the deceased and by drawing as much as possible from the child's own experiences (Koocher, 1973;

Ordal, 1980).

6. Emphasize the continuity of the generations Adults can illustrate the continuity of the generations or living on in one's descendants and can stress the passing on of values, advice, gifts, skills or traditions by the deceased (Ordal, 1980). "...[W]hile the dead must be dismissed, the values they represented in all their relationships must be preserved." (Marris, 1974, p. 31)

7. Stress the quality of life as being important. Emphasize that the quality of life is more important than the length of its span (Bernstein, 1977; Ordal, 1980).

8. Use simple, direct, concrete and factual terminology. Especially for children who have lower developmental conceptualizations about death, discussions should be kept in concrete rather than in abstract terms. Grollman (1967) advises adults to ask children to explain back what he or she has been told. This offers the opportunity to detect and correct any gross distortions or misperceptions on the part of the child. Grollman (1967) recounts one such distortion:

> I was once asked by a young girl, "How long is death?" I responded, "Death is permanent." The youngster said, "Oh, then it's not so bad." Noticing my bewilderment she said simply, "My mother has permanents all the time. It lasts for about six months." (p. 89)

9. Help the child to ask questions, express fears and feelings (Bernstein, 1977; Crase & Crase, 1976; LeShan, 1976; Nelson & Peterson, 1975; Wittmer & Myrick, 1974). Children are ready and capable of talking about anything within their own range of experience. The child has a strong need to talk, and does not need talking to (Hardt, 1979).

> When a child is in the midst of strong emotions he cannot listen to anyone. He cannot accept advice, consolation or criticism. He wants *us* to understand him. He wants us to understand what is going on inside himself at that particular moment. Furthermore, he wants to be understood without having to fully disclose what he is experiencing. (Ginott, 1961, p. 26)

Reassure the child that expressions of feeling, especially grief, are not only normal, appropriate and accepted, but necessary. It is the opportunity for emotional expression which differentiates the disturbed child from the

normal child. Baruch (1966) comments: "Here I think of a child, a very disturbed child, possessing many of the fantasies and feelings typical of 'normal' children, but so intensely loaded that they might seem quite otherwise" (p. 31).

10. Maintain consistency and support. It is important to maintain consistency immediately following the child's loss of a significant other (Dunton, 1970; Furman, 1974). Immediately following the death of a parent, for example, is not the time to further uproot a child by moving to a new location, changing schools, or hiring a new babysitter. The more consistency which is allowed to remain within the child's realm of functioning, the easier he or she may come to accept and replace the void which is left by the loss.

    Immediately after the death of a significant other, it is important that the child knows that he or she is part of a family (Blank, 1975).

11. Discuss opposites in life. For children, as for all of us, experience is made up of opposites. Researchers have considered the emotional-intellectual elements of a child's understanding of death as well as the magical-logical elements. But the child's grieving process illustrates other opposites including denial-acceptance, despair-hope, cry-laugh, life-death (Bowlby, 1969; Kubler-Ross, 1969; and Ordal, 1980). As we grow and develop we learn to cope with these opposites in our lives and to reach some sort of synthesis or resolution. Gibran (1963) writes about the integration of life and death: "For life and death are one, even as the river and sea are one (p. 87)." The Bible deals poetically with birth and death: "For everything there is a season and a time for every matter under heaven: a time to be born and a time to die" (Eccles. 3: 1-2). "Most of a child's education is for life which leaves him helpless in dealing with death. Such neglect is inexcusable and unnecessary." (Feifel, cited in Lonetto, 1981, pp. 11-12) In educating our children we can get them to view death as a natural part of life and to accept the "time to die" as well as the "time to be born."

12. Speak in terms the child understands (use the language of the child) and do not use sentimental language. Learn the child's talk and frame the discussion in his or her language (Ginott, 1961; Ordal, 1980; Piaget, 1973).
13. Comfort the child physically as well as verbally (Ordal, 1980).
14. Take time to understand what the child is asking or saying, do not complete the discussion in one sitting and be available (Bernstein, 1977; Crase & Crase, 1976).

Baruch (1969) pleads with therapists to give "attention, more hearing, more understanding ...to children's feelings." In this way, she tells us, "the normal problems of childhood remain normal"; "these preposterous giant imaginings do not create trouble. It is the way in which the child is responded to that determines sickness or health" (Baruch, 1966, p. 29).

15. Allow very young or nonverbal children to express themselves through play and art (Salladay & Royal, 1981).
16. Use media resources. There are numerous media resources designed to stimulate exposure to and thinking about death. Fassler (1978) reviews a number of books and teaching aids which are oriented toward helping children of various ages to know death as both inevitable, as well as a natural process. Ordal (1980) gives a comprehensive review of various characteristics which parents and teachers should look for when selecting books for the purpose of educating their children on death-related issues.
17. Have the child gradually say "goodbye" to the deceased.

> [The child must] actively resign himself to the impossibility of ever again satisfying his needs through interaction with the deceased. He must psychologically 'bury the dead'; only after this has been done will he be free to seek gratification of these needs from alternative persons. (Caplan, 1964, p. 89)

Atkinson (1980) contends that if the child is to make the necessary transition, he or she must gradually acknowledge the reality of the loss and emotionally let go of the deceased (Atkinson, 1980). In this way their energy is freed for investing in the development of new relationships.

18. Allow the child to attend the funeral. The funeral rite itself may be used

positively to afford the child a sense of closure, just as it does for adults (Greenberg, 1975; Kastenbaum, 1977; Koch, 1977; Koocher, 1973). Although in the past the sentiment seemed to be that the funeral ceremony was too macabre for children to comfortably accept, the more recent literature holds a different view (Greenberg, 1975; Grollman, 1968; Koch, 1977). Funerals have changed too, becoming less macabre. Greenberg (1975) explains that the funeral allows the child to experience the reality of death and share a sense of loss with other mourners. Koch (1977) points out that if children are not allowed to participate in the concrete rituals which are normally attendant at death, a child may be able to formulate or continue denial of death. If the child is to be included, he or she needs to be prepared for the activities of the ceremony by a trusted and familiar adult who explains fully why the funeral is being held, and describes as completely as possible what will take place (Koch, 1977). Koch (1977) contends that the child should then be provided with the option of attending or not, as well as the opportunity to refrain from any part of the ritual which may be disquieting (viewing the casket, for example). Simpson (1979) has concluded that a child, from the age of seven years on, should be encouraged to attend the funeral. The child's wishes should be recognized, discussed, and valued as a means by which he or she is attempting to to reconcile a loss.

19. Death education should be included in the education curriculum of elementary schools. Many authors and clinicians cite "death preparation" as a potentially beneficial coping mechanism. Fassler (1978) presents support for the concept that children who have been calmly exposed to death, either through loss of a pet or a distant relative, religious training, or by way of guided discussion, are less fearful of the event when it strikes closer to home. Mills and his associates (1976) and Kane (1979) refer similarly to a child's prior personal experiences as providing preparation for death.

Summary

In helping a child cope with death, it is crucial that the adult consider where the child is at conceptually, and to devise interventions and explanations accordingly. Adults should be open and honest and share their own feelings with the bereaved child.

The death literature has been concentrated in the area of basic thanatology theory, death conceptions and reactions and there has been a limited focus on providing counselling services to the bereaved and even less on services for the bereaved child. Attention in the literature has been given to several grief process theories, basic developmental guidelines and suggestions for grief work, but not on appropriate psychotherapeutic techniques nor on a specific framework.

## B. Crisis: An Opportunity for Growth

> During a crisis a relatively minor force acting, for a relatively short time can switch the whole balance to one side or the other--to the side of mental health or the side of mental ill-health. (Caplan, 1964, p. 27)

Lindemann (1944), whose bereavement study was foundational in the development of crisis theory, thought that unhealthy reactions to bereavement could be prevented by helping people grieve adequately. He found that avoidance of necessary emotions and distress served as obstacles of grief work (Lindemann, 1944). From crisis theory's early conception, crisis theorists have focused on grief and bereavement in establishing and developing a theoretical framework for crisis. Parkes (1972) and other writers have explored the subject of morbid grief reaction and Caplan (1964) extended the theories of crisis and the practice of prevention. By reviewing the works of some of the major proponents of crisis theory, a proposal will be made for its applicability to children.

### Crisis Theory

Crisis is mainly determined by the individual's perception of a particular event, but is usually associated with a stressful life occurence (Bloom, 1963). According to Caplan (1964), an individual undergoes crisis when faced with a

threat to basic sociological and psychological mechanisms which overloads his or her adaptive resources for awhile. The individual is atleast temporarily immobilized and unable to modify the resultant stress or tension through existing coping and defense mechanisms. Caplan (1964) proposes that the disequilibrium of crisis affords the individual a unique opportunity from which, depending upon certain endogenous or exogenous factors, he or she may emerge psychologically healthier than prior to the crisis through an extension of effective coping mechanisms and problem-solving skills.

Both Caplan (1964) and Dabrowski (1977), distinguished two types of crisis, "developmental" and "accidental". Developmental crises are those transitional periods of cognitive and affective upset which characterize the qualitative shift occuring in normal personality development. Accidental or situational crises, on the other hand are crises which occur suddenly, arbitrarily or "accidentally", representing a sudden loss. Included in this latter category is the loss of a loved one which is the type of crisis with which we are interested here.

Significant experiences with death can be more than tragic events with negative consequences for people. Benoliel (1981) suggest they may be conceived of as maturational crises through which individuals cope with themselves during times of adversity and change.

Crises As Maturational Tasks

On account of their importance in human relationships, Greer (1980) suggests that experiences with death can be viewed as developmental tasks that trigger and are a part of major life transitions. Accidental crises, he suggests, have the psychological features of transitional crisis, or of the "critical period" (Greer, 1980). A critical or "sensitive" period is defined as a "...turning point, a crucial period of increased vulnerability and heightened potential" (Erikson, 1968); and also as a period where the greatest gains and the greatest losses occur (Bower, 1974). It is said to be a time of life when both favourable and unfavourable circumstances can have lasting and irreversible consequences (VanderZanden, 1978); when certain things that happen at one point in time may have greater impact than if they happened at another point in time (Goldberg &

Deutsch, 1977). The three aforementioned concepts, importance of timing, the susceptibility or vulnerability, and the opportunity for "growth", are of prime importance in sudden accidental crises as well (Caplan, 1964; Dabrowski, 1977). While all critical periods do not involve crisis, it is suggested by Greer (1980) that each crisis represents a critical period. As such, these events and accompanying processes carry the potential for human growth as well as human deterioration.

Self-Enhancement Value of Crisis

Self-enhancement through disintegration, crisis or conflict is a theme emphasized by many writers of psychological theory (Bugental, 1965; Kubler-Ross, 1965; Dabrowski, 1975; Leitner and Stechner, 1975; Lindemann, 1944; May, 1969). Bugental (1965), an existential-phenomenologist, describes personal crisis as a precondition for growth and psychological change which often acts as a catalyst for an emerging new awareness. Lindemann (1944) maintains that an individual's attempts at solving a crisis may end in: a return to former psychic equilibrium; advancement to healthier integration; or, if the problem is overwhelming, nonadaptive solutions will restore equilibrium to a lower level. What Lindemann describes as "crisis" is labelled "symptoms of positive disintegration" by Dabrowski (1964), who regards external hazards as stimuli to the instinct of development and, therefore, in general, advantageous to personality development. Dabrowski concurs with Caplan, that disintegration may be part of the life cycle in the form of maturational crises, or it may occur as the result of accidental crises. Blank (1975) too, mentions that crisis need not be a wholly negative experience. It is a great challenge which can strengthen or weaken the ego, by integrating traumatic experiences into adapative capacities and so lead to greater maturity and strength (Blank, 1975).

May (1968), and other existential writers (Kierkegaard, Frankl), stress the confronting of tragic aspects of life and emphasize the experience of anxiety as an opportunity for positive growth. Accordingly, the fundamental "psychological malady" is the fear of "living fully." By repressing feelings, people cut themselves off from awareness of their own existence; people live in

partial reality, falling victim to a deadening apathy and sense of meaninglessness (May, 1968). If people consciously face and assimilate the full spectrum of awareness and feeling--no matter how unpleasant--they can become more fully human, or "self-actualized." Growth and creativity require that a person at least temporarily endure the stress of "being"; one does not become fully human painlessly (May, 1968).

The notion of crisis is integral to a number of life span theories of human development of which Erikson's (1950) is most notable. Erikson's theory on human growth sees personality as evolving through successful mastery over a series of conflicts and the successful reemergence from each crisis with an augmented sense of inner unity, a stronger capacity to perform well according to one's own standards and judgement of self and others. His work also points to the potential disruptive influences on human development of major changes when they overwhelm the capacity to cope with what is happening. His concepts of ego synthesis and resynthesis in the development of identity are equivalent to the Dabrowskian conceptualizations of disintegration and secondary integration in personality development (Dabrowski, 1977). Erikson (1950) sees the major emotional crises of identity as centering around three areas of human experience: the loss or threat of loss of someone very important; the injection of new and threatening persons and relationships; and changes in significant role relationships.

Crisis Matrix: Influential Factors in Human Responses to Death

Thus some events serve as potential catalysts to developmental change because they produce crises for which one's coping strategies do not work. There is much evidence to suggest that death-related experiences serve in this capacity and act as precipitating factors within a crisis matrix of other life experiences. In Chiriboga's (1979) view, the outcomes of major life transitions--whether toward growth or toward deterioration--depends on the matrix of contextual and interpersonal components surrounding the event and not the event per se. In Benoliel's (1981) framework, how individuals cope with death is affected by the kind and quality of resources available to them as

they search for new coping mechanisms and ways of understanding the changes around and within them.

Parkes' (1972) research in the area of death resulted in a source for identifying some of the factors that compose the crisis matrix: the combinations of personal and social factors that influence human reactions and behaviours in response to death. In his investigation, the outcomes of bereavement were determined by a combination of antecedent, concurrent and subsequent factors. He identifies the important antecedent factors as being: childhood experiences (especially losses and separations), previous mental illness, life crises prior to bereavement, relationship with the deceased (kinship, strength of attachment, security of attachment, degree of reliance, intensity of ambivalence--love-hate), and the mode of death (timeliness, previous warnings, preparation for bereavement, need to hide feelings). The concurrent factors he proposes as playing an integral role in determining bereavement outcome are: sex, age, personality (grief proneness, inhibition of feeling), socioeconomic status (social class, nationality), religion (faith and rituals), cultural and familial factors influencing the expression of grief. The subsequent factors he proposes are: social support or isolation, secondary stresses, and emergent life opportunities (availability of options). These factors can be viewed as composing a crisis matrix for analyzing any personal-social transition in which death functions as a situational crisis of serious dimensions. Parkes' thinking provides a basis for predicting who the high-risk candidates for disturbed or incomplete bereavement would be and is directly applicable to children. Many of these factors coincide with the determinants of children's response to death found in the sibling survivor study done by Cain and his associates (1964).

Greer (1980), in drawing from the work of cognitive theorists in this area (Lazarus, 1978; Taplin, 1971; Weisman, 1972) concludes that a principal factor to consider in preparing individuals for changes in life experiences is "person perception." In order to meet the threats posed by sudden changes in life productively (to transpose threat into challenge or to diminish counterproductive denial systems, for example) he maintains that it is imperative

that the individual generate certain expectations about such changes. The person would need to have assimilated into his or her perceptual repertoire: the inevitability of these events; strategies, cognitive or otherwise, for engaging the events, and the normal psychological sequence of such events (Greer, 1980). These events include terminal or incapacitating illnesses or death of a loved one, which are normative events for most individuals. Greer concludes that if there was an *early structuring* of expectancies regarding such events where they were treated not unlike the crises of adolescence, would remove them from the realm of "accidental" crises and place them in the context of developmental tasks.

An Opportunity For Children to Grow, Too: The Self-Enhancement Value of Crisis For Children

Developmental or maturational crises and "critical periods" have been explored in child psychology, but accidental crises and their impact on children have been virtually ignored. Although crisis theorists have limited their formulations and research to adult populations, there are a number of implications for and allusions which can be made to the self-enhancement value of crisis for children from the work of Dabrowski, Erikson, Greer and Piaget. Greer's conclusions, for example imply that childhood is the time to begin structuring death experiences and that when death experiences are incurred in childhood they can be treated as opportunities for facilitating emotional, psychological and conceptual growth.

According to Eriksonian theory, bereaved children are suffering from major emotional crises which have heavy impact on their sense of identity, capacity to cope with change, and feelings about self and others. These emotional crises centre around the child's loss of a parent or sibling (loss of someone of importance); the surviving parent establishing a new romantic relationship and remarrying (injection of new and threatening persons and relationships); and the taking on of a new position in the family constellation (change in significant role relationships). From a developmental viewpoint, the loss of a key relationship creates a maturational crisis with heavy impact on a

person's sense of identity, capacity to cope with change, and feelings about both self and others. Children are particularly prone to identity crises because their self-concepts and coping mechanisms are still forming. In fact, losses of key relationships in childhood can hinder the normal developmental processes and can lead to fixated behaviour at a level that interferes with the completion of personal and social maturation (Benoliel, 1981). However, if given guidance and support children can face and emerge psychologically strengthened from these crises (Erikson, 1950). Erikson (1950) sees human growth through the lifespan "from the point of view of conflicts, inner and outer, which the healthy person weathers, emerging and re-emerging with an increased sense of inner unity" (p. 218).

Piaget (1973) speaks of equilibration which involves two processes that instigate a state of cognitve imbalance followed by a new balanced organization at a higher level. The first process, assimilation, refers to the fact that objects encountered for the first time are not viewed as truly novel but rather as new examples of things already known. While physically manipulating such objects, children find that the objects will not fit into preconceived notions and cognitive imbalance between expectations and reality results. The second process of accommodation is then initiated. Accommodation refers to changes in the child's established mental structures to take account of the new object's unique properties, thus restoring cognitive equilibrium. As a result, the child's awareness of the world, in general, is broadened. The research conclusions of Kane (1978) and Swain (1979) previously referred to, support the Piagetian notion of equilibration and have specifically applied it to the child's formation of knowledge about death. For example, a concrete operational child who experiences the death of an age peer or sibling will experience conflict between this reality and his or her existing view that death comes with old age. Accommodation to this new experience will result in the modified conceptualization that death happens to young children, too.

Dabrowski (1977) describes a parallel process to Piaget's cognitive developmental model, in the psychological and emotional realms. He contends that

lower level psychic structures must dissolve before higher levels of psychological integration (equilibrium) can be attained. According to Dabrowski (1967), the pain and suffering of a child are fundamental to development of a more mature psychic structure--to an "'awakening of the inner [psychic] milieu,' for its restructuring, for differentiation, and for elevation of the level of sensations, for moral estimates and deeds...and [for] one's relations to the social environment (p. 169)." Situations in which the child experiences the loss of a significant other:

> ...may be used for the application of the method of the disintegration of primitive attitudes, because such situations, when one is interested in them or experiences them, produce natural sensitivity to given stimuli--that is, they produce a state of susceptibility to loosening, and consequently to disintegration. (p. 170)

The implications are that children who are experiencing bereavement are in a position to develop and reintegrate their "loosened" psychic structures on a more mature level. Anthony (1973), Bluebond-Langner (1977), Kane (1978) and Swain (1979) have carried out research which has suggested that an actual death experience for a child can stimulate more mature concepts about death, and life in general, that do not follow previously outlined developmental patterns.

Parness (1975), in working with preschool children who have sustained the loss of a parent or sibling, points out that "very young children have resiliency and fortitude in the face of some painful and unpredictable experiences life has to offer (p. 7)." Unless children can mobilize additional forces within themselves during crises, or are helped to do so, depression, anxiety and deterioration are threatening. The professional counsellor/therapist can be fundamental in facilitating the bereaved child's potential (since parents are often too emotionally laden with their own grief) to grow and re-emerge emotionally and psychologically enhanced from his or her death experience.

**C. Existentialism, Death and Children**

The existential view of death is encompassed in the basic tenet of crisis theory--that is, facing and confronting one's personal finitude or a death experience, is positive and not to be avoided since it has conceptual, emotional and psychological enhancement value. The following section reviews literature in attempt to explicate the value of working within an existential framework with bereaved children.

Existential psychology is the discipline most sympathetic to issues of life, death and their meaning, guilt, fear and mortal anxiety. While practically speaking, a skilled, empathic psychoanalyst or cognitive-behaviourist could be as successful in working with a bereaved child as an existential psychologist would be, existential concerns of the bereaved are central to existential theory and therapy.

Thus, in an attempt to lay the groundwork for my existential approach to psychotherapy (to be presented in the following chapter), I will elaborate on the existential perspective on death and I will present reports by professionals and researchers who contend that children have existential concerns which can be addressed pointedly. Finally, the existential approach to child psychotherapy (and existential psychotherapy in general) will be examined through the work of three main advocates of this approach. The value of an existential attitude and psychotherapy approach for working with the existential concerns of children will be conveyed.

**The Existentialist's Perspective on Death**

As conscious beings, we are aware that at some point in our future we will not "be"; we are beings that are living in dialectical relation with non-being, death (May, Angel & Ellenberger, 1958). "To be and not to be" expresses the fact that non-being is an inseparable part of being (May et al., 1958, p. 47). To grasp what it means to exist, one needs to grasp the fact that he might not exist (Heidegger, 1970). The existentialists hold that the confronting of death gives the most positive reality to life itself. Death is the one fact of life,

which is not relative but absolute, and awareness of this gives existence absolute quality.

In the existential view, death is not an event which ends life, but is a part of life; therefore it is always present and does not occur solely at the end of physical existence (Kaufman, 1976). Furthermore, death is not something that lies in the future, but rather, it is with us here and now, constantly and all-pervasively. Hence, death permeates all life. This implies that human beings must make their own situation in light of their mortality. Our mortality limits our possibilities by limiting time, and in so doing, it gives meaning to life that an eternal being could not experience. "Death becomes a goal, rather than a threat making living more urgent." (Heidegger, cited in Hardt, 1979, p. 4)

Kubler-Ross (1975) speaks of death as a meaningful growth producing aspect of life. She sees death as "the final stage of growth" (Kubler-Ross, 1975). It is the denial of death, she maintains, that is responsible for living empty, purposeless lives. Heidegger (1967) Kierkegaard (1974) proposed, that, in order to avoid torment and angst (dread) due to one's attempts to escape from mortality, a person typically comouflages these feelings by living inauthentically and conventionally (Misuak & Sexton, 1973). Such camouflaged living, however, brings feelings of guilt. Only by accepting the inevitability of death and non-being can a person experience authentic existence and freedom.

Death is what gives meaning to our lives:

> ...for when you live as if you live forever, it becomes too easy to postpone the things you know you must do. In contrast, when you fully understand that each day you awaken could be the last day you have, you take the time to grow, to become more aware of who you really are, to reach out to other human beings. (Kubler-Ross, 1975, p. 49)

**The Existential Concerns of Children**

> We have come to this day
> of astronauts...of missiles...of men with machines
> who handle with sureness
> the fingertip message of death.
> And yet-
> as man and woman,
> fathers, mothers, people with children-
> we are at a loss.
> From our shut-in places of silence we ask:

> What to do about feelings that keep us apart?
> Anxiety, anger.
> Anger that we have arrived at this pass.
> (Baruch, 1966, p. 30)

Bettelheim (1977) contends that with death issues and other existential concerns, we must, at each stage in our development--childhood, as well as adolescence and adulthood--find some degree of meaning consistent with the level of understanding we have already attained. It is important, he maintains, for each of us, child and adult alike, to gain a certain level of understanding of what the meaning of our life is or might be (Bettelheim, 1977).

According to Schneidman (1981):

> ...the question of life and death is an existential question and is an expression of the child's basic curiosity and search for meaning. Children, like other people, seek to understand themselves, their relationship with others, and the world in which they find themselves. (p. 253)

Oaklander (1978) recounts this existential search in her book *Windows To Our Children:*

> I remember very clearly what it was like being a child. It's not so much remembering incidents and happenings, but remembering the "being." I remember clearly that I had deep down feelings and knowings that I had never told anyone. I knew things. I wondered about life. I philosophized. And no one really knew this side of me. I thought about death and was in awe of the fact that life existed before I was born. I wondered at my parents having lived as long as they had, and questioned whether I would live a long time. (p. 320)

The literature reveals that most adults, therapists included, avoid discussing existential issues with children even though they are crucial concerns for all of us. Generally speaking, adults mention neither death nor aging, the limits to our existence, nor the wish for eternal life (Bettelheim, 1977). Bettelheim (1977) contends that existential dilemmas can be addressed briefly and pointedly thus permitting the child to come to terms with these issues in their most fundamental forms. "Discussions about death are necessary and should recognize and respect the unique reactions and choices of children while helping them to develop concepts of their personal existence." (Lonetto, 1981, p. 35)

The child is subject to desperate feelings of loneliness and isolation and he or she often experiences mortal anxiety (Moustakas, 1953; Bettelheim, 1977). More often than not the child is unable to express these feelings in words or

if so only indirectly. Older children may be afraid to express these feelings to parents as they fear that they may cause them pain.

> There are so many things a child thinks and feels and dares not talk about that he holds inside. If he so much as lets one of these push timidly out of its hole, he catches our look, our horror...[and] not the listening atttentiveness that trouble deserves. (Baruch, 1966, p. 31)

> It is interesting that when we talk about "getting in touch with the child in us," we mostly refer to the merriment of childhood. I'm also remembering that as a child, I allowed my happy-go-lucky self its expression (it got a lot of approval) and I certainly expressed some tears of pain and sorrow, and a bit of anger. But I soon sensed that these latter expressions caused pain in adults I loved, and I learned quickly to be careful about expressing them. I think most children get this kind of message and at some point begin to tone down their expressions. (Oaklander, 1978, p. 321)

Parents, it seems, tend to become uncomfortable when they recognize these feelings in their children and tend to overlook them. Often they depreciate their child's spoken fears to reduce their own dissonant feelings and falsely hope that by doing this they will alleviate their child's fears. Researchers and practitioners tend to agree that children of all ages philosophize at their level and have existential concerns. Moreover, they have the desire to discuss them with interested, attentive adults.

**D. Existential Child Psychotherapy**

Being in the world and with others are fundamental issues in existentialism. The existential psychotherapist sees therapeutic change as emanating from the 'being' with <u>one</u> other--the therapist. Through the ongoing nature child-therapist relationship, a new and concrete life experience is created and change occurs. It is in the very ongoing of this kind of relationship that the child is already different and more psychologically and emotionally balanced (Gendlin, 1966). In existential psychotherapy, the world of the client is grasped from the inside; it must be known and seen as far as possible from the one who exists in it (May, Angel & Ellenberger, 1958).

"The child therapist has an ear to their [the child's] heartbeat. And so let us talk about what the child hears. What this can mean to children." (Baruch, 1966, p. 31) Existential child psychotherapy, as practiced by its most renowned proponents, is both child-centred and unstructured. Both Virginia Axline (1947)

and Clark Moustakas (1953) have developed psychotherapeutic models which adopt the general attitude and approach of Rogerian Client-Centred Therapy. However, because their clientele are children, they have introduced a novel element into their unstructured approaches: play.

Play is the child's natural mode of expression and communication and through play the child can explore roles, refine various skills, develop social relationships and act out innermost feelings (Dimick & Huff, 1970). Adults talk out their problems, children play them out. According to Erikson (1964) play is the most natural self-healing measure for children; it is their form of self therapy (Oaklander, 1978). Friedrich Schiller's (1899) quote "man is perfectly human only when he plays" (p. 289) emphasizes the spontaneous, uninhibited and unpretentious nature of play. Common to all definitions of play in the Oxford English Dictionary is the sense of free (or willful) motion within (close) limits (1973, pp. 1603-1604).

Play therapy is an opportunity that is offered the child to experience growth under optimal conditions. As with existential therapies for adults, it is the general all-pervasive attitude of the therapist which is of prime importance in therapy and not his or her dialectical manoeuvres or professional techniques (Axline, 1947; Moustakas, 1953; and Oaklander, 1978). Moustakas (1953) defines play therapy as:

> ... as a set of attitudes through which children may feel free enough to express themselves fully, in their own way, so that eventually they may achieve feelings of security, adequacy and worthiness through emotional insight. (p. 5)

He believes in three requisite therapeutic attitudes: faith, trust and acceptance, which are communciable. Moustakas (1966) speaks of a "trance-like" state between child and therapist, a moment of awareness and discovery, called the "existential moment" where child and therapist are in full communion with one another. To him, living existentially with children means transcending theoretical frameworks and adhering primarily to the evolving, spontaneous self of the child. The following quotation sums up nicely and succinctly Moustakas' view: an authentic counsellor is always "Seeing rightly with the heart. What is essential. What is invisible to the eye" (Moustakas, 1966, p. 89).

Axline (1947) defines play therapy as "a vital opportunity that is given to the child to play out his feelings and problems--his fears, hatred, loneliness and feelings of failure and inadequacy" (p. 72). During Axline's play therapy sessions she accepts the child unconditionally and follows his or her lead. The eight principles by which Axline (1947) abides in her therapy are:

> 1. The therapist must develop a warm friendly relationship with the child, in which good rapport is established as soon as possible.
> 2. The therapist accepts the child exactly as he is.
> 3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely.
> 4. The therapist is alert to recognize the feelings the child is expressing and reflects those feelings back to him in such a manner that he gains insight into his behaviour.
> 5. The therapist maintains a deep respect for the child's ability to solve his own problems if given an opportunity to do so. The responsibility to make choices and institute change is the the child's.
> 6. The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way; the therapist follows.
> 7. The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognized as such by the therapist.
> 8. The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship. (pp. 73-74)

Both the Moustakian and Axlinian therapies are "self-directive" in that they are based on the assumption that the individual child has within himself or herself the capacity to solve his or her own problems and the ability to redirect his or her energies into self-actualizing behaviours. These therapies are unstructured. The therapist does not attempt to hurry up the therapy and recognizes it as a gradual process. Only those limitations are established that are necessary to link the therapy to reality and to make the child aware of his or her role in the therapeutic partnership. The child has complete freedom in terms of structuring the session, selecting the toys and setting the stage for play.

Violet Oaklander (1978), another existential child psychotherapist, employs a Gestalt approach in her work. Unlike Moustakas and Axline, she follows a more confining path with her young clients. Although the child is allowed to play in an atmosphere of acceptance, faith and trust this to her does not entail a structure-free setting. She often sets up a structured situation with toys for a child to enact a scene with. She may select suitable items to fit the child's

life situation or some mythical problem-solving dilemma, in psychodrama or role-playing situations. Her style seems more suitable than the Moustakian or Axlinian approaches in situations where a child is using play to avoid dealing with his or her thoughts and feelings. Oaklander believes that the therapist must deal with these situations directly but gently, once they are recognized.

Oaklander directs the child's awareness to his or her emotions and/or to the therapeutic process itself, and to the child's involvement in it, either during the play or immediately after. When a repetitive theme is evident in the child's play, Oaklander directs questions to the child's personal life. She approaches traumatic situations pointedly and believes that experiences with death need to be brought out into the open, talked about and even re-enacted symbolically. She finds that a kind of desensitization occurs in re-examining and discussing the experience.

In her directness, she is cautious not to disrupt the flow of the therapeutic process. She is extremely involved with the child and knows when the moment is right for speaking or asking the child to do something. By bringing the child's feelings, life situation and traumas into the open, a degree of synthesis occurs. Integration takes place both through the open expression (even though it may be symbolic) and also through the child's experiencing the play situation in an accepting atmosphere (Oaklander, 1978).

Play has become generally denigrated as the frivolous whiling away of the time and energies of children, but as we can see, it is of major therapeutic value in a counselling milieu. The Old English-Germanic "plegan" from which the word play orignates, means to pledge for, stake risk or exercise oneself. This definition accentuates the growth potential of play; it is only through risk-taking and variation that growth can occur.

Child psychotherapy, is not <u>all</u> play. "At times there are deep issues between therapist and child as they reach from the depths of hostility and despair to discover a healthy way of life." (Moustakas, 1966, p. 5)

> Crisis, shock, confrontation, resistance, struggle, rejection, defeat, as well as joy, silence, the excitement of discovery, the peaceful smile, and the gestures of affirmation and growth--all enter into the process of therapy, in which real persons, not ghosts engage in

> challenging struggle of wills and the enabling pursuit of meaning and the value of living." (Moustakas, 1966, p. 3)

The above quotations taken from Moustakas' (1966) book *The Child's Discovery of Himself* seem to support the "growth through crisis" approach to counselling. Instead of relieving the child of his or her despair, Moustakas believes the therapist should be there with the child while the grief and the pain are experienced and suffered. By letting the crisis peak in a therapeutic milieu, the child becomes free to formulate feelings of hope.

**E. Chapter Overview and Summary**

Even if it is not possible for an individual to conceptualize his or her own death, it remains undeniably true that children, like adults, can actually experience the death of a significant other and can feel the same sense of emptiness, loss, fear, guilt and ambivalence that adults do.

Professionals and researchers have examined some of the perceptions which children maintain of death, in order to provide a setting for the working through of children's grief in therapy. Researchers have found that children's cognitive frameworks surrounding death are age-related and that children move through stages in which they deny, personify and/or fantasize about death, before coming to see death as universal and inevitable.

The literature reveals that what has typically been overlooked, are the side-effects that tactics used to protect children from direct experience with death have. For example, in neglecting to address and discuss the subject of death with children, they are given the opportunity to create their own fearful and confused interpretations. If parents fail to share their own feelings and thoughts following the death of a significant other, children are left with the overwhelming burden of working through the crisis alone. Self-disclosure begets self-disclosure. If parents hide their true feelings from their children with the intent of protecting them, their children will feel obligated to do the same. Grieving openly with children, and acknowledging to them that grief is a normal and acceptable process, gives them the permission to share an otherwise overwhelming burden.

How adults and children cope with and react to death is not only related to their conceptual level, but to a number of other antecedent, concurrent and subsequent factors as well. These include: the current support network available to them, previous experiences with separation and loss, the intensity of attachment with the deceased, and preparation for bereavement. If a child is helped to confront and accept death, a course of healthy and enriched conceptual, psychological, emotional and physical development will ensue.

From the existential perspective, death permeates all life and gives it meaning. Accepting the inevitability of death and of non-being, opens up adults and children alike to authentic, free and quality living. Children have a genuine interest in existence-related issues, but adults who have unresolved existential concerns feel uncomfortable discussing them openly. An authentic, genuine existence, as called forth by existentialists, requires a facing of life's uncertainty, within ourselves and with children.

The existential psychotherapeutic approaches of Moustakas and Axline are non-directive and non-confrontive. They allow the "being" of the child to unfold naturally through the warmth and acceptance of the therapist and through play. Oaklander, on the other hand, appoaches traumatic situations pointedly and believes that experiences with death need to be brought out into the open, talked about and even re-enacted symbolically. By bringing the child's feelings and life situation into the open, she contends, integration and synthesis occur.

The literature seems to converge around the view that children have the fortitude and resilience to accept and confront their feelings and thoughts about death. This is true whether "death" involves their own impending death, death of a significant other or concerns about personal finitude. For children who are having difficulty coping adaptively with a death experience a confrontive, directive approach is likely to be the most successful. In the next chapter one such model is presented. What psychotherapeutic techniques can be utilized to facilitate the grieving process in children? The techniques which emanate from the philosophical attitude underlying the proceeding model, will be presented in chapter four.

The following six points serve as summary statements for the preceding literature review:

1. Children's conceptions of death are age-related and this may be due to maturational and/or social-experiential factors.

2. For the most part children's reactions to death are not unlike those of adults. They experience fear, guilt and the whole range of grief reactions which cause disturbances in both their cognitive and affective functioning.

3. The overwhelming consistent recommendation by professionals is for adults to realistically help the child confront and accept death. Adults should foster direct, honest and open communication.

4. Crisis theory, research by Bluebond-Langner, Dabrowski, Kane and others suggests that children can emerge at a higher level conceptually and emotionally, and might even be psychologically healthier following bereavement if helped to grieve adequately.

5. Children have existential concerns and these are often ignored or overlooked by adults.

6. Existential approaches are used for dealing with children in crises. These approaches, however, do not immediately generate any recommendations/techniques for working with bereaved children. For the most part, these approaches are non-directive and non-confrontive.

## III. MY APPROACH TO EXISTENTIAL CHILD PSYCHOTHERAPY

I am forever wrestling with conflicting thoughts over what exactly my counselling approach is and to which psychotherapy model I inadvertently adhere. I know that my existential presuppositions influence my work with children just as they influence my adult counselling relationships. I can accredit Moustakas for helping me more stringently formulate my conceptions of what an existential counselling framework entails for children. I know, too, that underlying my spontaneity and liveliness with children, I have a refined need to direct and control. I know that although I agree with the basic assumptions of child-centred therapy and that I espouse the general attitude inherent in this approach, I find that I must compromise this when adapting it to my personality and intergrating it into my own style. Just as two children enraptured in the harmony of play take turns interchangeably leading and following, I, too, take my turn. I become child-like in my actions, but then step out at appropriate moments into another face of my therapeutic role. In all there are three faces: player, confronter and promoter--PCP. As "player" I get lost in the child's play as we banter back and forth; as "confronter", I face and force the child to face a particular concern or dilemma; and as "promoter" I encourage the child to grow from the confrontation and move forward from his or her present situation.

My work with children is based on the premise that therapy is at its optimum and is most valuable when it provides a meaningful and unique life experience for the child and myself. After forming a therapeutic partnership with the child, we together explore his or her inner world by bringing it out and then working actively and directively to resolve existing conflicts and problems. I structure our sessions and invite the child to participate in various new experiences which are centered in self-awareness and self-direction. I attempt to "carry forward" the experiencing process by creating and adapting unique psychotherapeutic techniques for the individual child. I have no set way of using an existential approach in therapy. I am always versatile and vary from one moment to the next. My intuitive imagination flows with each particular

child's needs, as I see them, in order to fully enter into his or her ontological world.

My overall goal in therapy is to allow the child to become aware of his or her self and the place of that self in the world. I have adopted Moustakas' (1966) goals which involve: being sensitive to self of the child; facing the child fully at all times and trusting his or her capacity to re-emerge from traumas healthily; maintaining my individuality and not committing myself to a pre-established theroretical framework; continuing to regard the child as entirely new regardless of how he or she resembles children I have counselled in the past; and finally, committing myself to spontaneous, ongoing human processes that are sparked in the merging of a significant child-therapist relationship.

**A. PCP--Play, Confront, Promote: Attaining the Ultimate High**

It is important to acknowledge that the utility of the following model lies in its emphasis on structure and confrontation as effective therapeutic tools. The intent, here, is to present an argument in support of their inclusion in child psychotherapy and to examine their particular usefulness in bereavement counselling with children. As such, this discussion is predicated on the assumption that the reader will have some understanding and appreciation of the development of therapeutic relationships and of therapeutic process.

**Play: The First Phase**

When a child first enters into a psychotherapeutic relationship with me, I introduce him or her to the facility and its materials and then we play together. We jointly discover what this "new world" is all about. child's space, play, life events and stories. When I join in this way I have a better opportunity to introduce and move the child to new variations at a later time. This same process is reflected when I become engaged in the content of the child's thinking in order to move with him or her beyond ongoing conceptions.

As the spontaneous energy begins to flow, I go with it, and I subtly and slowly offer some direction to the play situation we have created. I continually

test to see if the child is ready to accept my lead, and if not, I wait until the right moment (as I intuitively see it) presents itself. During some sessions that moment may never come and in these situations I allow the child to continue as he or she pleases.

I induce structure so gradually and spontaneously that it appears natural, and often it is not apparent at all. When I introduce a game or a "technique" it is usually something I have adapted in the moment for the individual child. As my repertoire of games and gimmicks increases, I select a technique which can be easily adapted to whomever I am "experiencing."

Child psychotherapy is not <u>all</u> play. Piaget (1973) has stated that though play is "in service of intelligence", it is <u>not</u> developmental; that is play serves many vital needs and functions of the child's growth, but it is not in itself a source of conceptual, emotional and psychological growth. In other words, play, alone, does not guarantee a "working through" of the child's repressed feelings and thoughts. In therapy, after establishing a therapeutic bond with the child, I begin structuring the play situation in a way which encourages the grief-stricken child to express his or her ambivalent and intense feelings, and, confused and confusing thoughts surrounding the loss.

<u>Structure</u>

I define structure as anything the therapist does in therapy to lead and guide the child in a directive manner. This includes activities, questioning, confronting and any techniques used to facilitate the therapeutic process. It varies in intensity with the personality and philosophical assumptions of the therapist.

Most psychotherapists operating from an existential standpoint (Axline, Moustakas, and Rogers, for example) believe in an unstructured clinical atmosphere. I, on the other hand, believe that structure is not only advantageous, but necessary to help the child deal more effectively with "real life."

> Living, being human, implies limitations. Each person must come to terms with his limitedness, with the fact that he does nnot know where he comes from, who he is in terms of his capacities and abilities, and where he will go--his fate and the meaning of his life.

> This is the overall existential limitation, the nonbeing in living. In the course of his life, man will make what he can out of the unknown challenge that is given him.
>
> In addition to the existential limitation, there are limitations inherent in the specific situation into which each man is born and which in the course of his living he learns to accept. (Colm, 1966, p. 74)

Many existential therapists believe in an unstructured atmosphere; the only limits which are set are those devised to protect the child, therapist and the physical environment. I believe that in this regard their therapy is unrealistic; in the real world we are constantly and unendingly faced with limits imposed by others, by the environment, and by our very predicament as human beings. Without limits children may feel free, but this freedom does not guarantee that inner conflicts will be brought to the surface and confronted in therapy. By learning to accept and transcend the limits imposed in therapy the child is "practicing" for life. In a structured, controlled atmosphere the child may more easily be confronted with life meaning in the form of his or her feelings of loneliness, isolation, rejection and unworthiness.

A child who has experienced the death of a loved one, has had severe limitations placed on him or her. By comparison, psychotherapeutic limitations will not be viewed in a negative manner by children who have experienced such severe life limitations. Limitations restrict and narrow the decision-making process for the child. A child who has been hurt or confused by a loss, in my view, is not immediately psychologically prepared to make his or her own decisions. Structure for these children is synonomous with security. When they no longer need this security, they will resist the limitations imposed by the therapist which indicates that there is a readiness to take on responsibility for their own living. Resistance to therapeutic limits could also be exhibited by the bereaved child who is asserting anger deriving from his or her loss.

"No one seemed to care about me. Suddenly there were no rules and strictness in my home. ('Carol,' cited in Sarnoff-Schiff, 1977, p. 86)." Immediately after a death, there is a disruption of daily routine and the family's rules and style temporarily change. There are some more permanent changes as well. The family structure breaks down which necessitates change; (the family

hierarchy will change, roles will be redistributed, and affective needs will no longer be met by deceased person), and a jolting change in conceptual structure (death is no longer seen as being personally remote once it has come to a close family member). Structure for the bereaved child has been destroyed in both his or her external and internal worlds and the therapist can help facilitate its re-establishment. By structuring the counselling sessions, the therapist can promote structuring of the child's conceptual, emotional and psychological realms at higher levels and promote individual growth.

**Confront: The Second Phase**

Confrontations are typically avoided in both Rogerian and Axlinian therapies. Unfortunately the method of confrontation has become disreputable and associated with hardline Gestalt, Rational-Emotive and Reality Therapies. According to Gestaltists, discordant, unproductive behaviour results from an unnecessary polarization of elements within the individual which therapy seeks to dispel by bringing the elements together in direct confrontation. In the therapeutic relationship the therapist tries to find the discordant elements that are causing the conflict or the symptom, and create a dialogue, a confrontation, between them.

Moustakas describes a different kind of confrontation:

> In the confrontation there is an open facing of a powerful issue or conflict between two persons...The resources talents and potentialities of the therapist, his entire being must be present, facing the child, encouraging him to unleash deeper feelings. (1966, p. 4)

A confrontation in therapy may be defined as a conscious effort by the therapist to help the client examine the consequences of some aspect of his or her behaviour (Johnson, 1972). Johnson (1972) refers to confrontation as an opportunity for "self-examination" which arises from the therapist's desire for more intense mutual involvement with the client.

The intent of a confrontation is usually to free the client to engage in more productive and less destructive behaviour. The decision to confront is dependent upon the strength of the therapist-client bond and on the perceived ability of the client to act upon the confrontation.

According to Johnson, there are two types of confrontation: informational and interpretive. Informational confrontations involve communicating some information about the therapist's perception of the client's behaviour, its consequences and the therapist's reaction to it. The second form of confrontation, interpretive, involves taking informational confrontations one step further. Interpretations of the client's behaviour can be powerful stimuli to growth if they are communicated with skill, integrity and empathy. Interpretation potentially leads to insight and insight is often a key to psychological health and maturity. Interpretations are valuable to the client in that they are points of departure for action leading to growth (Johnson, 1972).

The characteristics of an interpretive confrontation are: empathy, and authenticity of the therapist, and timing, relatedness (to the behaviour), conciseness, and tentativeness of the confrontation statement (Johnson, 1972). Thus authenticity, a prime therapeutic factor for existential psychotherapists is also a prerequisite for an effective confrontation. Contrary to popular belief, confrontations can be genuine, empathic forms of communication and not necessarily abrupt, destructive, sterile, stark attacks on the client. Even Dabrowski's "disintegration method" is a gentle means of confronting and dissolving the child's current mode of functioning:

> When applying the disintegration method one should not, as a rule, intensify tensions, unrest, fear, and the feeling of guilt with an individual [child]...On the the other hand, it is advisable that certain forms of...disintegration of tenacious structures should ensue in a positive way--that is, through the strengthening of the individual's positive traits, his interests and capabilities....[By doing so,] the egocentric tendencies become weaker and the too tenacious instinctive structure loosens. (Dabrowski, 1967, p. 170)

Confrontations are not foreign to children--they confront each other and adults all the time. Children are basically uninhibited and have not yet incorporated tact, etiquette and deceit into their repertoire of social skills. It is this directness, this tendency to confront, typically found amongst the child's peers, which Dabrowski (1967) claims is "one of the important sources of refashioning the child's attitudes (p. 171)." Their confrontations are genuine and authentic; so too, should the therapist's confrontations possess these two qualities. The literature on children's reactions to death, on helping bereaved

children cope, and the crisis literature, concur that children have the fortitude and resiliency to face, confront and emerge healthy from traumas they have experienced.

**Promote: The Third Phase**

In the first two phases ("play" and "confront") of our joint experiencing, thoughts and feelings which are confused and confusing, disturbed and disturbing, surface. The thoughts are challenged and discussed and the feelings endured and accepted in the course of our mutual exploration. The third phase--promote--is one of synthesis and integration. Ambivalent feelings for the deceased are reconciled; conflicting thoughts are integrated. The worlds of fantasy and fact which had previously merged, now diverge. The child comes to understand more fully and factually what has happened. He or she has been reassured that it was not his or her coincidental and unacceptable wishes which caused the death, and that there will be no punishment in retaliation.

In the authentic, secure therapeutic milieu, the child gradually overcomes denial, anger and guilt; but the ongoing feeling of sorrow lessens only with time. Having sustained intense sorrow, happiness will be experienced more profoundly; having endured the ultimate in separation, attachments will become more consciously valued; and having shared deep-seated emotions, his or her humanity will be ennobled and deepened.

Promote is the third but not the final phase of therapy. "PCP" may occur once or several times throughout any one session and recurs continuously throughout the therapeutic process. It is a developmental spiralling process. Ideally the pattern of joining with, being challenged by, and growing from one's environment will continue beyond therapy and throughout life. PCP is an ongoing, recursive process. As new emotions are experienced and memories evoked through play and confrontation, new levels of accomodation and synthesis are encouraged. Disintegration and dissolution are basic to the grieving process; reintegration and resolution are basic to child psychotherapy.

**B. Four Therapeutic Goals in Bereavement Counselling**

In reviewing my bereavement counselling videotapes (and transcripts) it becomes apparent that I adhere to four primary therapeutic goals:

1. *exploring* the child's bereaved world;
2. *entering* and *remaining within* the child's bereaved world;
3. *encouraging* the child's expression of grief; and,
4. *facilitating* the development of hope and acceptance.

These goals underly my PCP model and each goal roughly corresponds to one phase of the model: goals one and two correspond to the "play" phase, goal three to the "confront" phase, and goal four to the "promote" phase. Since the PCP model is itself recursive, the goals are continuous and all-pervasive. In this next secton the four goals will be elaborated upon and followed by procedures and/or technical subcomponents which facilitate their attainment.

**"Now I Know Where You're Coming From": Exploring the Child's Bereaved World**

I regard "exploration" as a continuous process aimed at providing me with information about the child's ongoing experiencing of bereavement. Exploration, a means of assessment, serves as an indicator of how I can best enter, and remain within the child's world. Moreover, it provides me with a direction for how I can work within that world to promote expression and acceptance of it, with eventual transcendence above it. Since the child is constantly acting, reacting and interacting with me and with the environment, assessment is an ongoing and everchanging process. In my informal methods of exploration and assessment, I attempt to obtain the following information:

a. How does the child conceptualize death and the loss of a loved one? Which understandings are the child's own convictions and which have been imposed on him or her by well-intentioned adults?
b. What element of the death experience is affecting the child and how is it affecting him or her?

c. Are the child's grief reactions normal or abnormal? Do they require psychotherapeutic intervention?

d. What modes of expression and activity is the child most comfortable with (talking, painting, writing, role/puppet playing, for example)?

I have found many technical subcomponents/procedures to be useful in facilitating the exploration (assessment) of the child's world. These include the therapist:

1. using child-like thinking (concrete, literal)--to try and determine what the child might be thinking;
2. using child-like language (playful, simple, direct) and expressions--to facilitate the child's understanding of what is being communicated to him or her;
3. dialoging with the child--to elicit verbalizations of cognitions and affective responses toward his or her death experience;
4. questioning the child--to clarify in a way which does not discount him or her;
5. challenging (playing devils' advocate with) the child--to test the limits and depth of his or her beliefs, conceptions, convictions about death and his or her emotional responses to death;
6. encouraging relaxation in the child--to facilitate the process of getting in touch with deeper thoughts and emotions; and,
7. focusing topic specific discussion--either directly or indirectly (through projective buttons, for example).

**"Follow Me, I Know the Way": Entering, and Remaining Within, the Child's Bereaved World**

Entering, and remaining within, the child's bereaved world is essentially a multilevel process. It entails joining with the bereaved child on conceptual, verbal, physical and emotional levels. Two of the exploration procedures previously mentioned (using child-like language and expressions, and dialoging--bantering back and forth with child playfully, for example) help to

insure that the therapist's entrance into the bereaved child's world is a smooth one. Other procedures which facilitate the processes of entering and joining the bereaved child's world are:

1. perception and emotion checking--to verify the accuracy of perceptions;
2. reflecting back child's words--either verbally or by writing them down in the form of captions under cartoon drawings;
3. reflecting back child's feelings and overall presence by
   a. verbally describing how he or she feels;
   b. expressing back the same affect as the child;
   c. modelling the child's physical posture and positioning;
   d. staying on the physical level of the child (floor);
   e. drawing the child;
4. listening attentively and actively--to assure child that his or her feelings and thoughts are important and are being understood;
5. allowing the child to do most of the talking by prompting him or her to do so, if necessary;
6. encouraging the child to recount details of events surrounding the death experience--to facilitate the experiencing and the understanding of the child's world;
7. reminiscing with the child about the deceased--to share memories and to widen the world of joint experiencing;
8. communicating trust and faith in the child--by verbal praising and by allowing him or her to complete your drawing;
9. being playful with the child (tickling, joking, teasing)--to break the adult-child barrier, to facilitate therapeutic bonding, and to complement the bad and difficult times;
10. working on a mutual project (drawing, video production)--to facilitate joint experiencing and to emphasize working toward a common end.

**"Let It Be": Encouraging the Child's Expression of Grief**

This goal essentially corresponds to the "confronting" phase in therapy. The child is encouraged to confront and face feelings of guilt, sorrow, and despair surrounding his or her significant loss.

When encouraging the child's expression of deep, intense emotions, the following procedures are useful:

1. creating the desired mood (joy, sadness)--by playing music;
2. communicating non-verbally--through music;
3. direct the child to specific emotional issues--either directly or indirectly (through music with pertinent lyrics);
4. persistently direct the child--to insure the confronting of conflicting thoughts and ambivalent feelings (through psychodrama and/or role-playing;
5. have the child enact ambivalent feelings;
6. explain the importance of confronting burdening emotions and thoughts--by saying something like "You know what? If you hate it [the 'scary' feeling] we have to find out exactly what it is so I can help you...okay?";
7. allowing the child to re-experience the event and the attendent feelings by:
   a. showing a film/filmstrip of an age-peer going through a similar process, and/or
   b. first heightening and awakening the imaginative abilities of the child by appealing to his or her fantastic, playful and magical nature and then having the child speak directly to the deceased and/or re-enact the event through psychodrama;
8. encouraging the child to share memories, recent and past, of experiences shared with the deceased; and,
9. encouraging the child's awareness of self and feelings--by drawing his or her portrait and/or cartoon strip of child as he or she currently presents.

**"Somewhere Over the Rainbow": Facilitating Hope and Acceptance Through Synthesis**

Synthesis and integration occur throughout the therapy process by bringing the child's ambivalent feelings and confused thoughts out into the open. There are ways, however, of taking these feelings and thoughts which emerge and facilitating further synthesis through insight. Karen, for example, had dichotomized the good and bad feelings she had for her deceased brother and expressed them in the form of voices of the devil and God. I had her make a chart: on one side she wrote all the names of people who reminded her of the devil; on the other side, she wrote all those who reminded her of God. In the process of doing this, Karen came to the realization that there is some of the "devil" (bad) and some of "God" (good) in all of us. More importantly, she realized that there is some of both in her as well. That is, her ambivalent feelings were not only normal and natural, but acceptable as well.

When attempting to facilitate hope and acceptance through synthesis, I find the following procedures to be useful:

1. opening the child up to new ways of coping and problem-solving--by rehearsing methods through play and psychodrama;
2. discussing and demonstrating alternative ways of keeping the memories of the deceased alive;
3. having the child say "good-bye" to the deceased (as he or she knew the deceased in this life); and,
4. having the child work on a project (drawing, video-production) which is a concrete means of:
   a. packaging thoughts and emotions,
   b. in a medium which can be shared with others and which is eternal, and,
   c. which he or she can find a special place for.

**C. "Well We've Gotta Say Goodbye": Termination of Therapy**

Termination of therapy, a type of "death" experience, is important for all client-therapist relationships but especially so for bereaved children. Termination of the therapeutic relationship is typically the first major separation since the child's significant loss. As a child learns to accept the physical and emotional separation of a significant other that has died, he or she becomes better able to cope with future separations. Starting a project with a definable end (such as the video production), and completing it, helps metaphorically facilitate termination for the child. Psychodrama is one way of determining whether any "unfinished business" remains as termination approaches, and whatever surfaces can be dealt with in the course of the enactment.

In our final sessions I recount and reminisce with the child about our shared psychotherapeutic journey. We recall specific experiences in therapy, the happy times and the difficult times. We remember the diversity of emotions endured and how they were dealt with (open expression, drawing, playing) so that the child can deal with them when they surface again. I let the child know that these feelings will be back, though somewhat less intense with each recurrence.

Following their two month absence (summer vacation), I met with Karen and Jeffrey separately. I was pleased to see Karen move about the playroom independently, self-assuredly and self-directedly--no longer needing our partnership to further her discovery and healing processes. We said goodbye. I said, goodbye to Jeffrey, too, for his mother felt comfortable helping him work through his unresolved feelings. We continue to maintain regular contact--my invitation to see the children in therapy is always open.

**The Healthy Child**

How do I know when the child is sufficiently healthy to terminate therapy? I look for the following subjective and behavioural changes before terminating therapy:

1. A decrease or amelioration of symptomatic behaviour, including fighting,

hallucinations and failing school performance.

2. The child's subjective experiences become more positive. Fears, guilt feelings, and anger toward the deceased are replaced by positive feelings and a renewed sense of self-confidence;
3. The child can generalize adaptive means of coping with intense emotions to situations outside of therapy.
4. The child begins to invest in relationships with peers once again and becomes involved emotionally with intimates other than the deceased.

## IV. TECHNIQUES AND THEIR APPLICATIONS

### A. The Suitability of Techniques for Existential Child Psychotherapy

Traditionally the use of techniques has been downplayed in existential psychotherapy. Though the existential approach might embrace various techniques, it is the authenticity of the process, itself, which is viewed as therapeutic. Existentialists argue that when techniques become the focal point in therapy, clients are seen as merely machines which can be operated upon by the therapist. "Human beings as machines" is the world view espoused by behaviourists and runs counter to the existential view of human nature. Existentialists emphasize that it is the "more and different living" provided in a therapeutic encounter which makes therapy efficacious, and not the techniques per se.

Existential psychotherapists also espouse the concept of spontaneity. In order for the therapeutic process to be successful the therapist must be able to focus and respond moment-by-moment to the child and his or her experiencing. I contend that this is more easily done by the therapist who has a storehouse of therapeutic tools from which to choose. The more tools a psychotherapist has at his or her disposal, the more the right combination can be adapted for each individual client.

In further defense of techniques, I believe that there are certain techniques which can be used to promote deeper meaning for the client and to provoke thinking about existential issues. "Gimmicks" are especially useful with children as they are attracted by playful methods of interaction. It may be difficult to maintain a flow of conversation with a child over the period of an hour; and, it may be unproductive to just "play" for an hour, but by pulling out an appropriate technique when the right moment presents itself, the therapeutic process may be facilitated and enriched.

Existentialists say that a person is made by the living that he or she does and hence a person changes only through more and different living (Gendlin, 1966). I am proposing that techniques themselves can be used to

expedite this new and different living. Techniques may be used to subtly provoke a child to explore foreign or forbidden territory.

Techniques inevitably become associated with and even surface to the forefront of existential psychotherapies. Prime examples in which this has occurred are Client-Centred and Gestalt Therapies. Reflecting of content, perception-checking and the "two-chair technique" and the "hot seat" are to Client-Centred and Gestalt therapies what contracting and systematic desensitization are to behaviour therapy.

Like Rogers, I did not set out to develop a theory nor did I premeditate what techniques I would employ; rather, they developed and emerged with and from practice. And, as I look back on my counselling encounters, I am able to classify some techniques and use them when the moment is right.

Maslow (1968), a renowned existential advocate, states that if we want to learn more about children, we had better develop techniques for getting them to tell us how it is for them, and what is best for them. My creativity and spontaneity with children has enabled me to create techniques in the moment, techniques which allow me to enter the world of children, while remaining within the realm of existentialism. The following techniques are my attempt at translating existentialism into practice.

> It is easier to produce ten volumes of philosophical writing than to put one principle into practice (Leo Tolstoy).

**B. Karen and Jeffrey: Two Bereaved Children in Therapy**

In the following section, I will recount and provide excerpts from my counselling sessions with Karen and Jeffrey, to illustrate how I work existentially with children and to elucidate the techniques I am proposing.

Initially eight year-old Karen was referred to me over concerns about her personal disorganization, lack of self-esteem and confidence. A few days subsequent to our first session, her four year-old brother died in a fire he and Jeffrey accidentally caused. The primary focus of our sessions became Karen's bereavement, while the original referral concerns subsumed a secondary role. Two months after the fire, six year-old Jeffrey was referred to me for

bereavement counselling. Their mother's concerns centred around the increased amount of fighting the two children were engaging in; her own tolerance for it was understandably limited. In addition, Karen was "hearing voices" and was afraid that she was being followed. Jeffrey was being haunted by the ghost of his brother; both children were extremely fearful of natural separations (sleeping, being left alone in a room, their mother's death). I had seen Karen for ten sessions when her brother joined us for two (on my recommendation based on their mother's concerns). I saw Jeffrey, alone, for two further sessions. We terminated, temporarily, when the children went out-of-province for their summer vacation.

**Crisis Matrix**

There are many factors which predisposed Karen and Jeffrey's conceptions of and reactions to their brother's death. Several of these factors have been previously outlined in the research of Cain and his associates (1964) and are referred to collectively by Parkes (1972) as a "crisis matrix." The children's *Roman Catholic background*, for example, seemed to colour their responses to Ricky's death (afterlife notion of heaven; the voices of the devil and God). Another factor which should be considered is that the child have already had *one experience with separation and loss*. Four years prior to the accident, their parents were divorced and their father moved out-of-province. They did not see him again until Ricky's funeral. Furthermore the death Ricky's death was *sudden and accidental in nature*. The guilt feelings are naturally intensified in such a situation as are fears of retaliation. The fact that it was a *sibling death* opposed to the death of a parent would tend to increase the children's feelings of vulnerability--that death does not only come to the old and fears that they might be next. Finally, the *support network available to the family was limited* and their mother endured much of the mourning process alone. These factors are representative of those that may have influenced the nature of the children's responses to Ricky's death and to therapy.

## C. Psychotherapeutic Techniques

The following techniques are illustrated by transcribed excerpts and are accompanied by running commentaries. Within each techique the reader will recognize several of the procedures and technical subcomponents which were outlined in chapter three. The themes of "play," "confront," and "promote" flow through the excerpts as do the four implicit therapeutic goals. The chapter ends with a technique which can be utilized by the therapist to determine therapeutic success by interpreting the child's artwork. Two of Karen's paintings are presented for illustrative purposes.

While these techniques and excerpts implicitly reflect the model I presented earlier, they are not to be considered inseparable from it. My intention is that the reader, as therapist, will integrate and adapt these techniques to his or her own purposes and assumptions, and to each individual child.

### "Grey Skies Are Going To Clear Up:" Dialoging and "Unclouding" Confused Conceptions

Oh call my brother back to me
I cannot play alone;
The summer comes with flower and bee--
Where is my brother gone?

(Felicia Hemans, cited in Sarnoff-Schiff, 1977, p. 85)

The following excerpt is from my first session with Jeffrey, alone, a few months after his brother's death. He initiates the dialogue as he completes a family drawing.

And here's our whole family, but Ricky's dead so he's in...um in this cloud.

He's in a cloud?

He's in that cloud.

I was up in a plane and I didn't see him.

I know but he's in heaven; heaven is that cloud.

I didn't see him in the clouds.

How come? Yeah, because he was lying down. Because he was invisible when you came.

Oh, can he do magic?

Yeah he can.

Yeah?

Um hmm.

He can go invisible if he doesn't want someone to see him?

Yeah, but he can see us right now. Right? But here he is sitting behind me, but he's invisible.

He's beside you?

Behind me. (I move over to where Jeffrey has indicated that Ricky is sitting) Don't sit on...Now he's on this side (Jeffrey's laughing).

Why don't you talk to him?

No, we can't because he won't talk to me.

Did you try?

Well, he can hear us but he doesn't talk.

How do you know?

Because God told me.

When did God tell you?

When he brung Ricky up [to heaven] he said (speaking in a deep voice trying to portray God) "Ricky can't talk."

He said what?

"Ricky can't talk!"

God said that to you, eh? What else did God say to you?

Nothing else.

That's it? What if you could talk to Ricky, what would you say to him?

I don't know. But he's in the stars, too.

In the stars, too. Gee...What if you could say something to him. Just think what would you say? Think hard. If you could have one chance to talk to him.

Um Um...Well he won't tell me anything.

But you could tell him. What do you want to tell him?

(Whispers to me. He's pretending that he's talking to Ricky) Last night guess what we had?

(I whisper back) What?

We went to MacDonald's.

You went to MacDonald's?

Right now he's invisible. Right now he's here.

He's here and in the clouds?

He's in our hearts. He's in our hearts.

Is he in my heart?

He's in everybody's heart.

I don't see him.

Yeah because he's right in your heart.

Can he fit in my heart? I thought he was big like this (indicating his height with my hand). He's about like this big.

Uh uh...No...I'm going to the rocking chair.

> Dialogal research demands that the researcher be dialogically conversant with his subjects at some phase of research. But dialogue takes place only among persons on equal levels, without the divisiveness of social or professional stratification: dialogal research dispenses with researchers and subjects, and takes place among co-researchers. (Friere, cited in Colaizzi, 1978, p. 71)

In a sense, Jeffrey and I are "co-researchers" on a mutual search for his self-discovery. I communicate on his level verbally and conceptually. To do this I use child-like language and expressions ("He can go invisible" and "He's like this big."). My dialogue with Jeffrey consists of short, simple, concrete, repetitive, and reflective statements, which often mirror Jeffrey's own. I test the limits and depth of Jeffrey's beliefs, conceptions and convictions about death (his brother's), in attempt to discern what he truly believes. I challenge him by: playing the "devil's advocate" ("I was up in the plane and I didn't see him."); by my naive, child-like questioning ("Oh, he can do magic?); and, by demonstrating the inconsistencies in his thinking--inconsistencies which come about through taking what he says literally ("He's here and in the clouds?" and "Can he fit in my heart? I thought he was this big." and by moving to where the ghost of Ricky is apparently sitting on the couch). I create dissonace for Jeffrey to facilitate the development of more mature conceptualizations. "Children do not

simply adapt an older person's perspective. They ponder issues, discuss them...and constantly try to broaden their frame of reference." (Sternberg & Sternberg, 1980, p. 127)

As a follow-up to our interaction we explored the more abstract meanings of the various expressions ("loved memories" for "he's in my heart," for example) which as they stood literally, provided little, if any, solace for him.

Making judgements about what children think based on what they say is a difficult task, and a skill which I continually try to develop by maintaining regular contact with children. Piaget (1973) addresses this issue:

> The essence of the critical [interpretive] method is...to separate the wheat from the tares and to keep every answer in its mental context. For the context may be one of reflection or of spontaneous belief, of play or of prattle, of effort and interest or of fatigue...there are certain subjects...who can be seen to reflect and consider, and there are others of whom...only talk rubbish in their replies.
>
> It is impossible to state here the precise rules for the diagnosis of these individual reactions; this must be the result of practice. (1973, p. 21)

**"Whose Been Sitting In My Chair?": The Magic Chair**

Do you have a good imagination?

Yeah.
Okay, come here. I've got something I want to do. But it's kind of tough...I don't know if you can do it. Do you think you can try?

I don't know.

Okay. Come here, we'll do it together. You have to go in a special chair for doing what we're going to do.

How come?

You'll see. Sit in this chair (a reclining chair).

Yeah.

And I'm going to sit right beside you on the couch. Okay?

Yeah.

Now, you have to close your eyes. This is a very magic... This is a magic chair. Okay. Now if I turn this light on... (I turn the main light off) Okay?

Yeah.

You have to concentrate very hard. Are you concentrating? (I'm leading him into a state of relaxation. I'm speaking very slowly)

Yep.

Now you can put your hands down on your lap and relax. Close your eyes. I'll sit right beside you. Now what I want you to do is breathe in and out slowly. breathe in. You have to relax. It's a very special chair. And for little kids who have a good imagination. Are you listening to me? (He nods his head to indicate to me that he is listening) They can do whatever they want in that chair and magic things sometimes come true. Now, what I want you to do.

Yeah.

Is pretend. And you have to pretend that you're at home right now.

Yeah.

And you're on your living room couch.

Yeah.

And Ricky comes into the room.

Yeah.

And Ricky sits on the couch, too.

And now's your chance to say whatever you want to Ricky.

Ummm.

You're going to think really hard and say something to Ricky that you'd really like to say to him.

I love him.

You love him? Tell Ricky that you love him.

I love you Rick.

And now's your chance to say whatever you want to Ricky. Okay, he can hear you now. What else would you like to say to him?

We had Coke at MacDonald's and french fries and hamburgers.

Ummm. So you're telling him that you had all that good food at MacDonald's. What else can you tell him?

That's all.

What would you like him to tell you? Close your eyes. He listened to you. Now it's your turn.

(He misunderstands what I have asked of him) Rick, you're my best friend. Would you come through again? (Rick, will you come back to me?) I can't do any more.

Do you want to come do it beside me? (I sense that he is uneasy, but I want him to stay with his uneasiness) You come sit on the couch beside me and do it.

With this? (He wants to know if he should bring the chair)

No, you can do it on the couch.

(He exclaims in surprise) The couch?? *This* is a *magic* chair. (He can't do it on the couch. After all the chair is magic, or have I forgotten?)

(I had forgotten) That's right.

Maybe it can come true next week. I don't want to do anymore.

Relaxation exercises serve as a vehicle for reaching deeper levels of experiences and feelings about death (Sternberg & Sternberg, 1980). Initially I had hoped that Jeffrey might reveal the sequence of events which led up to his brother Ricky's death, an accident which they both inadvertently caused. I thought that once I had diagnosed "guilt" or "remorse" I would have Jeffrey apologize aloud, in attempt to relieve him of it. As the session progressed, however, no such feelings surfaced (they did in future sessions). Instead Jeffrey chose to tell Ricky about his dinner at "MacDonald's." This seemed to be his child-like manner of reminiscing about something special they had shared. What surfaced was a longing for Ricky. Jeffrey had lost his "best friend" whom he loved. If his wish could come true, he would like Ricky to "come through again."

In creating the mood for this technique I build up the fantasy and mystique around it by using a reclining chair and by my manner and intonation (what Oaklander calls her "fantasy voice"). At first I spoke in a hypnotic trance-like manner; pacing my words to the rhythm of his slow breathing. As soon as he came under a light trance, I gave him suggestions. After awhile I sensed his discomfort. I wanted him to stay with this so I encouraged him to continue by sitting beside me. He was puzzled. After all, what we were doing could only work in the *magic* chair. Jeffrey became enraptured in the enchantment of *The Magic Chair*.

**Pinned Down: Amorphous And Morphous Buttons**

Buttons and pins are the big craze for children through to young adults these days. Rock stars, Kermit the frog, Miss Piggy, rainbows and clowns are pictured on the clothing of the youth of the eighties. Moreso than the clothes we wear, the buttons we choose reveal a lot about our character.

As a child psychotherapist, I have come to see how this attraction can be polished into several innovative psychotherapeutic techniques. I create my own buttons which gives me flexibility in the manner in which I employ them. Basically, I have used buttons in four major ways: (1) to focus discussion and generate topic-specific conversation; (2) to facilitate the therapist-child partnership; (3) to reflect the therapeutic and/or grieving process; and, (4) as a projective technique.

In my bereavement counselling sessions with Karen, I employed all four of the above methods. Once, for example, I wore a pin of an egg which was "sunny side up", and had printed on it "Keep Your Sunny Side Up". This immediately attracted Karen's attention; she read the inscription but was puzzled by what it meant. After I explained it to her, she exclaimed "You wore it for me. You're trying to help me look at good and fun things besides Ricky's dying." I paraphrased what I thought she was saying back to to her "We're looking at the good things in life as well as the bad things." "As well as the sad things," she added. Later on in the session she drew a picture of me and included the button along with it's inscription in her drawing. There were no letter reversals or spelling mistakes which were characteristic of her schoolwork. This implies yet another potential use of buttons.

A second way in which I have used buttons is in facilitating the child-therapist partnership. In one of my first sessions with Karen, I wore a "Miss. Piggy" button. She could really relate to it and she was likely thinking to herself "Hey, here's someone who really understands kids." I gave Karen the button and she wore it to many of our future sessions.

I used different buttons to reflect the grieving process through which Karen was going. In the beginning, I wore buttons of sad clowns and drooping

flowers to refect the sadness, lightning and thundercloud buttons to reflect the anger, and towards the end, I wore buttons of rainbows, pretty flowers and happy clowns to reflect hope and acceptance. There were times when Karen commented upon the buttons and times when she would include them in her drawings, and there were times when she simply overlooked them.

I have found that wearing amorphous buttons can serve as a projective technique. I have worn buttons, ambiguous in design, which have evoked various projections from clients, students and professors alike. A young boy who was a "pinballaholic" saw a machine in a button and Jeffrey saw a house this house was consumed by fire! in that same button. Thus sometimes buttons help me "pin down" where the child is at during any particular counselling session.

These techniques were all developed through discovery. Initially, I wore the pins because I knew children were attracted to them; now I wear them for psychotherapeutic purposes.

**"My Heart Belongs to You": Missing and Reminiscing**

So how was your week?

Oooooo, really scary.

Scary, eh? What happened?

My house burnt down. That's why I wasn't here last Thursday.

Yeah...I missed you.

Where did you think where I was?

I didn't know. I kept phoning and the phone was out of order.

Well the phone was out of order 'cause our house burnt down.

That's right.

Did you find out...

Yes.

...that our house burnt down?

I bumped into your mom.

When?

Yesterday.

Yesterday afternoon?

Um hmm. How did you feel about it?

Umm oooooh. I was scared. I was.

Come sit here beside me.

I wasn't there because I go over every Saturday, just about, to Elaine's house. I'm always there--I go over.

So you were over at your friends in the morning?

Yeah and um, my little brother Richard.

Yeah I know, I met him last week didn't I?

Yeah (she smiles, remembering my playful interaction with him.

What happened?

He got killed. He's in heaven and he's an angel.

An angel. I'm sure he's an angel.

In heaven.

How do you feel about that?

I'm glad that he's in heaven, but I'm not glad that he died.

You're gonna miss him.

My whole family's gonna miss him.

* * * * * *

Five minutes later in the same session...

Richard wouldn't talk to me last week.

He was shy.

Yeah, a little bit shy, I guess.

He's always shy. Poor little thing. Boy is he ever cute. (She laughs as she reminisces. She is confusing present with past tense--the full impact of his death has not registered yet)

I know he's cute. That's the first thing I thought when I saw him in that chair all bundled up.

All bundled up. (Deep in thought, reminiscing) He was all bundled up. I sure miss him. I even forget what his face looks like. (laughs)

Do you have any pictures of him?

No, we lost them all in the fire.

That's right.

We had one [a picture in which Ricky was] running around with no pants on just a shirt.

Oh no! Did he like that?

He was just a baby.

Yeah, that's cute.

Boy, did he ever look adorable. I'm gonna miss that little kid.

* * * * * *

Ten minutes later...

How does Jeffrey feel now?

Really sad.

He's really sad? What did he say to you about it?

He's scared. He's real, real sad. He didn't want Richard to get hurt. Richard didn't get hurt. (she is trying to convince herself)

* * * * * *

Twenty minutes later...

You should see his little coffin.

It's cute?

Yeah.

Did they have it open?

Yeah--no. No they're not allowed to open it. It was locked so no one...No well it wasn't locked but it had a lock. And Richard has a teddy bear inside.

Ahhh. He sleeps with his teddy bear?

In his coffin.

Yeah? Ahhh.

I'll bet you he'll come back every night and sleep with his um teddy bear...(silence as she contemplates) I sure miss that little kid. He'd be out by now.

Out where?

Out of the hospital....The doctor told us later....You should have seen his face (she imitates the doctor's face by pouting)....He said "Richard didn't make it." Me and Jeffrey started crying (nervously laughs). It was a hard--scary that day. First day this ever happened to me.

Yeah, it's not easy is it? (I touch her arm to comfort her and keep my hand

there)

First time, too. Would you be scared if you saw an ambulance, you thought your mom was asleep. And I wrote a note for my mom (remembering). I guess my mom didn't get it. "I've gone to Debbie and Elaine's house, love Karen."

Um hmmm.

"Dear mom: I have gone to Debbie and Elaine's house, love, Karen." The scariest day of my whole entire life. My whole entire life. And Debbie comes home and yells out "Fire, fire, fire!" And we said "Oh bull!" So we go over to my house and then we say "That's true!"

In the above segment Karen speaks with urgency. It is important for her to talk and for me to allow her to do so. I say only what is needed to acknowledge my understanding. She knows that I am with her by my attentiveness and non-verbal cues. I do not distract or redirect her when she discusses sensitive subject matter. I reflect her feelings and her words. It seemed important for her to recall the funeral and recount the impactful experience of seeing the coffin. I was very deeply touched by the way she spoke and of what she spoke. I communicated this to her, and by my presence, encouraged her to continue. I facilitated her getting in touch with memories of her brother by reminding her of my meeting with him. I kept close to her--physically and emotionally--and gave her the freedom to do what she most needed to do "miss and reminisce."

**My Mona Lisa: Child As Subject In Counsellor's Drawing**

By making the child the subject of my drawing I am giving him or her the subliminal message "Hey, you're really important!" or "Hey, you're cute" or "Hey, I like you enough to draw you". Often these messages are not accepted when they are given directly. This technique serves to facilitate the child's development of self-worth and feelings of self-esteem.

By "drawing" attention to certain aspects of the child's features or manner of dress by exaggerating them (in the drawing), the therapist can increase a child's self-awareness. For example, Karen, who was initially referred to me because of concerns over her lack of personal hygiene and general unkemptness, would often wear her socks only half on and dragging on the floor. When I drew her picture, I drew her socks exactly how I saw them.

She laughed and told me to "fix them." I assured her that I would alter the drawing once she had fixed her socks. She did, and then I did, too. She never came to session with her socks (or her "self") dragging again. "Clarity of image, whether in a looking glass or in an emotional mirror, provides opportunity for self-initiated grooming and change." (Ginott, 1961, p. 40)

There are numerous applications of this technique and its use in bereavement counselling with children. For example, the therapist can draw facial expressions on the drawing to reflect the child's current mood and feelings--be they hurt and anger, or despair and depression. By arranging the character appropriately on the page, the body and its relationship to its environment can be drawn to focus the session on the stage of grief that the child is presently at. "Isolation" and "anger" are relatively easy to depict, but for "acceptance" and "hope" the therapist might need to resort to cartooning. Captions might be added below or comments written in bubbles above the characters. Ideally these techniques will elicit discussion and the expression of emotions. On a latent level the therapist is communicating to the child "I am with you. I know where you're at and I understand how you are feeling."

Inevitably, this technique creates lighthearted fun and enjoyment. Once the child discovers that it is he or she that is being drawn, he or she will find it humourous as in the following case example.

> Karen looks at my picture and laughs incessantly. I say: That's you I tried but if I was looking at you all the time I could do a better job (an honest statement on my part, phrased and expressed in a child-like manner). You're smiling (I have drawn a smile on the face of the character. I am attempting to reflect her feelings of happiness and relief as she has just finished sharing with me the events and emotions surrounding her brother's death. Also, I see that the intensity was becoming too overwhelming for her; I want her to "cheer up")...Some rosey cheeks and I have to draw some frostbite on your...(I don't want her to forget the trauma of accident. Frostbite is something she has been preoccupied with since the accident. Her mom and surviving brother were frostbitten and she mentioned being frostbitten on the way over to our session from school)." She intervenes and exclaims: "Oh God It's just windburn. It looks so funny (she is laughing)."

**Being "On the Level": Emotional, Verbal and Physical Proximity**

Being "on the level" is a colloquiallism we use to imply being honest with one another. An authentic and genuine therapeutic relationship assumes that we are honest, truthful, and "on the level" with our clients. Following is an example of where Karen directed questions about death and afterlife toward me and I was "on the level" with her.

Karen and I viewed a filmstrip about funeral and burial rites. Her brother's funeral was "scary" and confusing for her. So we "relived" it in a therapeutic milieu in which she could openly ask questions. After viewing a filmstrip, the following exchange took place:

> Is Ricky really underground? Under dirt?
>
> You know that people are buried underground.
>
> Yes I know but I didn't think it was like that. What happens to us after we die?
>
> Karen...(pause)...I'm not sure. (She comes over to sit on my lap and we hug each other)

I acknowledged my uncertainty openly and honestly to Karen. I do not recall what words were exchanged after this. The soundtrack for the tape did not work. I remember "being there" with Karen one hundred percent and her being on my lap. I was overwhelmed with emotion and so was she. Our interpersonal co-existence was intense. A I watch the videotape I can sense the intensity, but am unable to recreate the verbal exchange (nor could I immediately after the session). I felt like we were in a trance-like state and I assume we were experiencing what Moustakas terms the "existential moment". As the intensity peaked Karen cried, and I held her.

I believe that it is crucial to face the child in moments of despair and crisis. I become physically and emotionally closer to the child as the despair and anxiety mount and as the existential crisis peaks. In reviewing the sessions in which I co-existed with various children, I see how I motion them to move closer to me as I encourage them to pursue sensitive subject matter. In the final few minutes of a session with Karen:

Who's your best friend?

In school?

No. Just your best friend anywhere.

Elaine.

Is she in your class?

Yeah.

Do you talk to her a lot?

Yeah.

Do you talk to her about what happened? (about her brother's death)

No. I don't tell her <u>that</u>. She doesn't. She doesn't understand. I talk about it only to my teacher and you.

We're the only ones that understand. (Karen lies down on a pillow. I lie down and mirror her position on the floor beside her).

Let's paint. I like painting. (She's trying to change the subject).

So do you have any friends that you can tell your feelings to? (I want to know if her friends are supportive. I know that this is sensitive subject matter for her, but I want her to be aware of it and face it).

No. No one understands.

Why don't you think they understand?

I know they don't understand because they're all small.

Do you think I understand? (There's a pause. She is not sure that I can understand fully as she is aware that what she is experiencing is unique to her. She <u>does</u> know, however, that I am with her and that I am attempting to share her experience as best I can).

(She finally answers...) Yeah.

The above interaction illustrates three types of "being on the level". Firstly, I am using physical closeness to facilitate emotional closeness. Secondly, I am using simple child-like words and expressions; I am on her level verbally as well. Thirdly, our communication is authentic and genuine--we are altogether "on the level" with one another.

Thus emotional closeness can be facilitated by mirroring the child's motions, by holding his or her hand, or by having him or her sit on your lap during moments of despair and moments where crises are being re-experienced. Using child-like language and expressions, being honest and truthful with the

child, and answering his or her existential concerns squarely and pointedly, will not only facilitate emotional involvement, but will enourage self-direction and self-awareness.

**"DaVinci, Will You Complete My Mona Lisa": Having the Child Complete the Counsellor's Drawing**

Children inevitably will admire the artistic creation of a significant adult. This can be used to a therapeutic advantage in the counselling setting. By allowing a child to complete a drawing, the therapist is communicating to the child trust ("I trust you will do your best job in finishing my drawing for me) and faith in his or her responsibility ("I think that you are responsible enough to be able to complete this drawing that I have worked hard on"). As the child undertakes this challenge, the therapist should provide positive feedback as to how the child is doing. It has been my experience that a child feels worthy, self-confident and experiences a higher self-esteem during and immediately after the picture is complete. The long term effects seem to be a stronger therapeutic alliance and bond between therapist and child.

This technique can be used projectively; the therapist can interpret what and how the child has drawn the additions to the picture. Once, in a group therapy session, I had the children draw life size pictures of themselves. I asked for help in completing mine as a couple of members of the group grew restless waiting. Two boys competed for the opportunity and I asked that they both cooperate and share the challenge (which they did successfully). They put a smile on "my face," meticulously drew my cowboy hat pin (Aha proof for the attraction of the almighty pin), and drew my hands "reaching out."

In a session with Karen, I have her complete the picture I had started of her...

> Boy was I ever scared (she is talking about the accident).
>
> You were all scared. Do you want to sit on my lap and add to my picture? (In case she is too shy to come sit on my lap I give her a reason for doing so) You finish my picture.
>
> No. (I interpret this as "No, I'm afraid I'll ruin your picture.")

Come on. You put the body on it okay? I don't know how to draw bodies (I am being honest with her, I am out of practice and have difficult figure drawing. I am sharing my insecurity with her, hoping that she will feel uninhibited enough to draw).

I don't know how to draw bodies ("I am insecure about drawing bodies, too.").

Come on, try. You did a good job here (I'm pointing to what she has already drawn) Do it just like that ("I like that, can you do one like that for me?") Come on... Fix it for me...

Okay I'll put the body on (She sits on my lap. She acknowledges that she wants to be close to me.). Can you draw the rose? (I am helpless, can you draw the rose for me?").

You draw the rose ("You are capable of drawing it yourself but I will guide you.").First draw the round part...squiggly over there...Very good. Very good (See not only can you draw a rose but a very good one"). Now draw the leaves underneath it.

I've got to colour it (Now I'm into the swing of things. I feel confident enough to go on.". We both laugh as she pulls her shirt so that she can see the rose on it).

You can go look in the mirror. (We laugh)

I've got green leaves on it.

What an artist! ("You're doing a terrific job!")

I can't draw bodies ("I still am not confident enough to draw the body on this picture.").

(I laugh) Let me see what you can do to that body. I'm not going to finish it anyway, so you can do what you want. Okay? Try it.

(She laughs)

(I guide her) First do the body...like the stomach (she laughs)...the little tummy. You need to draw the tummy first. Come on...(I poke her in the stomach).

Keep your hands away from my stomach please (giggling).

Oh, you're ticklish, eh?

You're right, I'm ticklish (giggling).

(As I wiggle my finger towards her, she laughs). I didn't touch you yet. Boy, are you ever...I'm not even near you. Okay go ahead, draw the picture.

(laughs) Ahhh. (disapproving of what she has drawn)

That's okay, go ahead. What's the stomach doing out so far on the right? (I'm teasing her)

No...No, no, no!

What's that?

That's my hand.

That's your hand. Good, very good.

Ooooh (dislikes what she has drawn)

Your hands "got frostbit," eh? They're blue (teasing her, I'm referring to our discussion about frostbite earlier on in the session).

What?

Look at that. You've got an orange face and blue hands.

No--you draw [drew] the face ("that's why they're not the same colour)!

Okay, you're doing great.

I've got blue mitts on.

That's a good one (we laugh). That's a good way of working it out.

There, I've got blue mitts on.

What about the rest of the body? Now you have to draw the legs.

No. (she laughs)

Go ahead. What colour are you going to use?

Blue jeans. Blue everything.

You even feel blue, don't you?

Um hmmm.

In the above interaction I use this technique to facilitate emotional closeness and rapport between Karen and myself. I do this by encouraging her to sit on my lap (as she becomes sad after discussing the death of her brother) under the pretense of completing my drawing. While in the process of completing it, she experiences feelings of insecurity, playfulness and happiness, and finally, back to the "here and now" as she experiences sadness at the realization of the loss of her brother.

There are a few projective aspects which, should be interpreted cautiously. Karen chooses to draw the rose first which signifies to me that she wanted to focus our interaction toward happier things. She was avoiding or prolonging the drawing of her body. She was not yet one hundred percent comfortable with me and did not feel secure enough to draw something she might make a mistake on, in front of me.

Overall, there are numerous applications of this technique, a few of which have been illustrated here.

**Dr. Jekyll and Mr. Hyde: The Two-Cushion Technique**

> The psychological rule says that when an inner situation is not made conscious, it happens outside, as fate. That is to say, when the individual remains undivided and does not become conscious of his inner contradictions, the world must perforce act out the conflict and be torn into opposite halves. (Jung, 1969, pp. 70-71)

The two-cushion technique is my modification of the "two-chair" Gestalt technique. The cushions, add an important dimension for many reasons. Children are more comfortable on the floor and chairs only serve to distance the child from the therapist. When child and therapist are both on the floor they are both on the same physical level. This physical equality encourages emotional closeness; a being on the same level as the child emotionally.

Pillows are easy to throw around and lend themselves to an informal atmosphere. Because they are easy to pull over and set up they can be arranged quickly and conveniently without disrupting the intensity and flow of the child-therapist interaction. The child is attracted by this "game" and with some encouragement from the therapist, is able to present two sides of a polarity which the child might otherwise have difficulty in segregating. Children experience many dichotomies: trust-distrust, denial-acceptance, good-bad, happy-sad, hope-despair, and logical-magical. According to Bettelheim, polarization dominates a child's mind; a person in the eye's of the child is either good or bad, stupid or clever, beautiful or ugly, nothing in between (1977). Two cushions should be used in this technique, one to represent each side of the dichotomy.

When it became known to me that Karen was hearing voices of the devil and God, I responded to this immediately in our next session. Though she had been hearing the voices for three years, their frequency increased and their content and quality changed following the accidental death of her younger brother. The manifest content of the voices was a hatred by the devil for both Karen and her brother; and a love of Karen by God, and a reassurance that

God was taking care of her little brother:

I'm going to put two cushions down here (I place two large cushions side by side), and I want you to pretend that one cushion is the devil...when you sit here you have to be the devil, and one cushion's God....I want you first to close your eyes...Close your eyes...Okay? Breathe deeply in and out (I pace my breathing with hers, we both breathe slowly. I also pace my words in rhythm with our breathing). And relax (She is relaxing and breathing slowly). Good. Okay...keep relaxing and keep your eyes shut. Don't fall asleep on me. Close your eyes...

(She peeks at me) I might [fall asleep], I'm tired.

That's okay I'll wake you up.

Close your eyes and listen to what I say. (She checks up on me to see what I'm doing).

I'm relaxing, too. (I assure her) Okay, now what I want you to think about is think about the things that the devil and God say to you in your mind. And they've been saying them to you for a looooong time. So first I want you to think...You don't have to say anything, just think...I want you to think about what the devil says. (She acknowledges that she is doing this) Okay, now close your eyes and think about the things God says. What kind of things has He been saying? He's been saying those things for a looooong time. Okay. Got them in your mind now?

Yeah.

Okay. This pillow's going to be God and this pillow's going to be the devil.

I'm God. (Insinuating that I, the therapist, will be the devil since I'm leaning on the 'devil' pillow).

I'm not going to be either. I'm going to be watching, okay? First I want you to be God and say all the things God says to you in your mind. And then I want you to sit here and be the devil and say all the things...

I can't say swears ("The devil says swearing words.").

I'll let you say swears just in this room, okay?

Okay.

Sit on the pillow. Concentrate okay, don't look at me... look that way...Sit on the pillow facing that way. Go ahead. Now you can start acting like God and say the things he says to you in your mind.

I can't do that.

Why not?

It's hard.

Okay, just concentrate. (There is silence for about twenty-five seconds).

(She speaks in a trance-like voice) "Karen...(silence) Forget about the

devil. Karen, I love you." (laughs, nervously breathing out).

Okay, what else does he say?

I can't remember.

Close your eyes.

I don't want to do that again (yawning).

Close your eyes and concentrate.

I can't do any more of this.

I think you're doing fine so far, and I want you to keep going.

See, like God says the nice things but the devil says all the mean things and...I hate it

You know what? If you hate it we have to find out what exactly it is so I can help you with it, okay? So sit on the pillow and concentrate, Karen.

(Silence for twenty seconds before she continues) "Karen...you're brother's with me....Karen (another twenty-five second pause) Ricky's sitting on my knee." I can't remember. That's all I can remember that God would say.

That's all you can remember?

That's all I can remember.

Okay, now Karen move over to the 'devil' pillow and try and remember all the mean things the devil has been saying to you in your mind. Remember...he's been saying these things to you for a looooong time.

"Fuck off Karen! Karen I hate your brother. I fucking hate God!"

What became apparent to both of us was that these voices represented two parts of her own character. She hated herself, and felt guilty for letting her brother die, for not being there to help him. Moreover, she was afraid of being punished for not being there. This manifested itself in her fear of being followed. She would constantly check over her shoulder to see if someone was following and she would check under her bed at night. "I even check under my bed and I don't even have a bed!" (She was temporarily sleeping on a mattress on the floor.) She was angry at him for playing with matches, and for leaving her; for making her suffer and grieve. But, on the other hand, she knew that she did not intentionally leave him and let him die, and she also knew that it

was not right to be angry at someone who is dead. So these two latent, conflicting parts of her personality were manifest in the form of foreign voices, voices of God and the devil.

Utilizing the "two-cushion" technique facilitated Karen's analysis of her internal structure. Presenting the polarities inherent in her feelings and thoughts permitted her to comprehend the difference between the two. Finally our discussion enabled her to put the polarities in perspective.

This technique is especially appropriate for bereaved children, whose conceptions of death contain emotional and magical aspects as well as intellectual and logical elements. The grieving process illustrates other opposites such as denial-acceptance and despair-hope (Bowlby, 1974; Kubler-Ross, 1969; and Ordal, 1980). Each side of the dichotomy can be acted out. As children encounter death experiences they are forced to learn about these opposites in their lives and to reach some sort of synthesis and resolution between them.

**"I Believe in Music, Oh, I Believe in You": Music in Therapy**

> Music exalts each joy, allays our grief, expels diseases, softens every pain, subdues the rage of passion and the plague." (Armstrong, cited in Gaston, 1968)

Historically music has been used for curing, soothing and mood changing. The most powerful form of nonverbal communication, communicating from one spirit to another, music can influence behaviour in strong and subtle ways. Music is often played by bereaved adults and adolescents who choose to lament their loved one's death.

According to Gaston (1968) in his foreword to *Music in Therapy*, most experts agree that music therapy's three most important accomplishments are: the establishment or re-establishment of interpersonal relationships; the bringing about of self-esteem through self-actualization; and, the utilization of the unique potential of rhythm to energize and bring order.

Music enlivens and energizes the therapist who is then able to transfer this energy to the child. Music allows the therapist to flow with the natural hyperactivity of the child, and by doing so, satisfies the child's physical need

for movement. The child is then free to continue exploring his or her inner turmoil; being more attentive and less distractible, allows deeper issues to be confronted and explored. Dancing to music with the child can facilitate the development of feelings of social adequacy. The child "loosens-up" while moving about, and can transfer this loosening-up to the exploration and expression of emotions. Finally, the therapist can select music with lyrics which are significant to current happenings in the child's life. The songs can be used to develop a theme upon which the session can be based; for example, loss, love and/or hope.

By conveying the warm emotions that bring people together, music often provides a bridge over the verbal impasses between therapist and client. Sensitive subject matter, such as death, can be approached via songs selected for their terse, poetic lyrics and their pertinent subject matter. Songs are played by bereaved adults to help them reminisce about their lost loved ones.

To encourage Karen to feel comfortable in speaking about the voices she was hearing, I played a popular ballad in which the devil and God confront one another. In listening to this song, Karen became "freed up" to discuss something she had experienced, but not shared, for three years. The scenario follows:

> Karen and I sit down to listen to the song Spanish Train by Chris deBurgh. When the song concludes, I turn off the record player and...
>
> What does it remind you of, what are they talking about?
>
> They're talking about the devil.
>
> The devil and who else?
>
> God.
>
> God and the devil. What do you think about that?
>
> Nice. But I hate the devil.
>
> You hate the devil? What do you know about the devil?
>
> He's dumb...stupid.
>
> He's dumb.
>
> He...The devil is not real devil...He's a Christian that got sent out of the sky.
>
> Ohh. Do you ever think about the devil and God?

Yeah, I hear their voices in my mind.

You hear their voices in your mind? What do you mean by that?

I mean I hear their voices in my mind. You...you should ask me how long this has been going on for.

How long has this been going on for?

Since I was in grade one.

Since you were in grade one? And now you are in grade three.

Yeah, and it's still going on.

What do the voices say?

One's swearing words and one's not swearing words. One's God and one's the devil.

What kind of things does the devil say?

Scary.

Like what?

Mean things. Mean things about my brother Ricky...Mean things about me...

Prior to this counselling session, these voices were not elaborated upon by Karen to therapists, teachers, nor to friends; and they were mentioned to her mother only incidentally. Karen was aware of the bizarre nature of these voices and could not expose them for fear of being ridiculed. I knew, however, that she wanted to be relieved of the burden of hiding them and that she needed an accepting atmosphere in which she could explore and understand them. As Moustakas (1966) says: "...the child must be free, must be even encouraged to maintain his own identity, his own ideas, his own perception of reality, no matter how disturbed they may appear to the therapist" (p. 5). By playing a song analogous in nature to the voices she was hearing, I was able to communicate the message "Karen I know about the voices and they are not as far-fetched and foreign as you now feel they are." I accepted her idiosycracies and what seemed like pathological symptoms, which demonstrated to her that she was not alone, even though her experiences were atypical.

**"If She Can Do It, So Can I!": Social Learning Through Filmstrips and Films**

I found filmstrips to be extremely valuable for facilitating emotional expression in the bereaved child. One filmstrip which I found particularly useful is entitled *Death: A Part Of Life* produced by Kliman (1978). It is about the feelings of depression, denial, anger and guilt which often accompany the death experience of a significant other. The story line follows the psychological and emotional growth and experiences of a nine-year old girl whose father recently died, as she struggles for equilibrium with her mother, her angry brother, her two classmates who feel awkward relating to her and finally with her empathic and attentive grandfather. Karen, herself, was angry at her surviving brother and wished he had died in place of four-year old Ricky. She felt her friends could not understand her because "they're all small." Her mother was too "grief-stricken" to deal with Karen's emotions.

Karen was able to identify with this girl of the same approximate age and shared her experience vicariously. As Karen viewed the filmstrip she became extremely absorbed and re-experienced her feelings along with the protagonist. At times she became teary-eyed as the pain intensified, at times she giggled nervously as she recognized things she herself did, but mostly she just watched, completely immersed and completely in touch with her death experience.

York and Weinstein (1981) produced a videotape about a family coping with death based on the theories of Rogers, Bandura and Walters and McLuhan. Its aim was to help bereaved children to freely express feelings and emotions. Their research found significance for the hypothesis that "the frequency with which children talk about the loss of a significant person will increase after viewing the tape" (1981, p. 357) The rationale behind this is that a non-directive vicarious experience (Rogers) in which the major actors may be viewed both as peers and models (Bandura & Walters) encourages viewer participation (McLuhan) and self-expression in depth (York & Weinstein, 1981). Karen's experiences were consistent with this rationale. She more readily and deeply expressed herself--her feelings of anger, guilt and depression--after

viewing the filmstrip.

**"Lights, Camera, Action, Roll 'Em": The Child As Star**

It is exciting and fun for children to hear their voices on tape and for them to see themselves on television. As a follow-up to viewing *Death: A Part of Life,* I encouraged Karen to "star" in a similar production. I let her know that she was being videotaped and I instructed her to share her feelings with other children who experienced the loss of a brother. We made up a list which would serve as a reminder of what she was to talk about:

1. My name, age, grade and who is in my family.
2. Where I was when my brother died and how I found out.
3. How Ricky died.
4. How my mom feels.
5. How my other brother feels.
6. What the kids at daycare say.
7. How my friends at school act.
8. How I feel now.
9. What Michelle and I do.

**"Act 1, Scene 2--Let's Play House": Psychodrama**

Enacting thoughts surrounding the death of a significant other through dramatic play, and experiencing possibilities through imagination, allows children greater insight into their situation and also leads to directions for healthy conflict resolution. I usually allow the child to structure the psychodrama as he or she chooses and then, while in process, I subtly direct the psychodrama to fit circumstances in the child's bereavement situation. "By doing this the child fits unconscious content into conscious fantasies, which then enable him to deal with that content." (Bettelheim, 1977, p. 7) Unguided psychodrama is cathartic; guided psychodrama offers an outlet in which the child can externalize what goes on internally in controlled ways. By acting out the various facets of his or her inner experience the therapist can help the child sort out what

otherwise would remain confused.

"The play's the thing wherein I'll catch the conscience of the king." (Shakespeare, *Hamlet*, Act 1, Scene 2, line 591). While "playing house" in a session with both Karen and Jeffrey, I was assigned the role of mom. They set up an evening scenario and told me that they would wake me up and give me breakfast in bed the next morning. I told them I did not like to sleep in because they might get into mischief. Karen knew exactly what I was referring to and she replied: "We won't play with the lighter." She continued speaking to me as though I was her mother when she told me that she was out when the accident happened--that she had left me a note which was destroyed in the fire. She felt extremely guilty and responsible for not being there to oversee her two brothers, the morning of the fire. I responded by saying that it was okay that she was out, that I believed she left me a note as she usually did. Then I said: "I trust you." She looked noticeably relieved and absolved of some of her guilt feelings.

**"Dear Diary": Keeping "Tabs" On the Therapeutic Process**

Having the child draw or paint a picture each session, provides me with a "picture diary" as one means of measuring therapeutic progress. Drawing and painting are traditionally used by therapists to join with children, as catharsis for the non-verbal child and/or as a projective technique to determine the child's ongoing phenomenological world. Keeping one picture from each session and filing it away chronologically, too, is a valuable technique. By doing an intra-session evaluation of these paintings, especially after several sessions have lapsed, the therapist is provided with an index of whether or not the child has progressed in therapy, and if so, how successfully.

The two paintings, which appear on the following two pages, illustrate what I am ultimately trying to "promote" in therapy. The painting appearing in Figure 1 was painted by Karen during our first session. I asked her to draw a picture of herself. The stark quality of the picture--the empty head, void of emotion, lack of detail, isolation of the figure, cloudy sky--is indicative of the

sorrow, aloneness and loneliness she was feeling at the time.

The second picture (see Figure 2), by contrast, drawn in our eighth session together depicts a bright sun suggestive of "rays of hope." There is acknowledgment of Richard, her dead brother (his mouth is masked, indicating that he cannot talk, and he appears immobile). She has drawn the two of us (I am the one with the barettes in my hair) together, smiling. She has learned to "be with" others again and no longer feels isolated by the experience of her loss. She has found a special place for her brother (he is drawn as an angel in the top right of her painting)--in heaven, in her memories, and in her heart. She has begun to perceive her brother's death not only as a loss, but as a gain, of sorts. She has been "promoted" to life and living once again. "Both children are doing very well now. Karen has not lost any of her newly found self-confidence and Jeffrey is a normal playful seven-year old." (Coleman, Note 3).

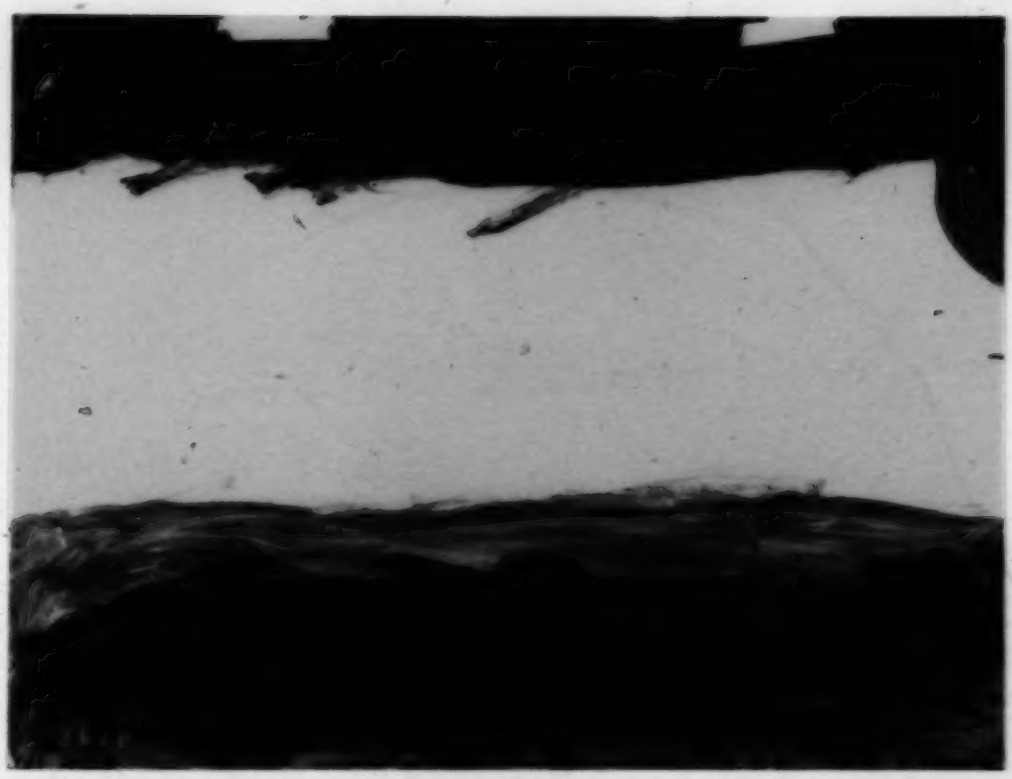

Figure 1. Karen's first session painting.

Figure 2. Karen's eighth session painting.

## V. DISCUSSION

The discussion is organized into seven sections. The first two are an integration of chapters two through four and attempt to answer the question: Is my current model substantiated by the existing literature as well as by my experiences with bereaved children in therapy? In the first of these sections, my experience in therapy is shown to be consistent with the children and death literature reviewed; in the second section PCP is analyzed in light of crisis theory and the "helping children cope" guidelines previously outlined. The third section is a personal comment on the cyclical as opposed to the linear view of death. The next two sections present the study's limitations and its implications for counselling and research. The final section, a concluding statement, completes the study.

### A. Children and Death: Conceptions and Reactions

My clinical observations of two bereaved children are consistent with the literature which reports that children in "middle childhood" (six through eight years):

1. personify death in the form of ghosts, angels and monsters (Nagy, 1948; Steiner, 1967);
2. attribute hearing but not speech to the dead person (Kane, 1978);
3. are confused by and/or fail to integrate adult explanations which are too abstract for them--"he's in my heart," "he's in that cloud," "he's in the stars," for example (Grollman, 1970; Rudolph, 1977; Salladay & Royal, 1981);
4. can experience the whole spectrum of human reactions associated with grief--guilt (Cain et al., 1964; Blank, 1975), fear (Anthony, 1940; Becker & Bruner, 1931; Caprio, 1950; Kotsovsky, 1939; Salladay & Royal, 1981), sorrow (Grollman, 1970; Dreikurs, 1964) and despair (Bowlby, 1980);
5. fear retaliation for having somehow "wished" the death upon the deceased (Anthony, 1940; Salladay & Royal, 1981); and,
6. are candid and direct about their thoughts, beliefs and feelings when adults

are (Freese, 1977; Ginott, 1961);

7. have the fortitude and resilience to confront their death experience and emerge psychologically renewed and self-confident from it (Parness, 1975; Rudolph, 1977).

**B. PCP--Play, Confront, Promote**

Before presenting an analysis of PCP, it is important to qualify that when implementing this model, I do not focus exclusively on death. "Neither the sun nor death can be looked at with a steady eye (La Rouchefoucauld, cited in Hinton, 1972)." The rationale for the limits I have put on this study is that there is no existing model which specifically addresses how a therapist might help a child work through thoughts and emotions related to the death of a significant other. The focus of this thesis, therefore, has been to provide one such model and the decision was made to illustrate it with excerpts in which death-related issues are being dealt with. In my sessions with Jeffrey and Karen, however, death was not dealt with directly in each and every session, nor was it addressed throughout any one session.

**Crisis Theory**

In PCP, I apply the basic crisis theory tenet--that the disequilibrium which follows crisis is an opportunity for psychological growth via the extension of one's coping mechanisms--to children. PCP is a process of incubation (play), disintegration (confront), reintegration (promote), incubation (play). Each reintegration occurs on a higher level.

In the process of PCP, I pace, reflect and mirror the child's verbal, emotional and physical being in an effort to enter into his or her bereaved world. By fully joining with the child in this way, I am in a position to challenge, confront and encourage the child to move beyond current conceptions, emotions and thoughts which may be debilitating or ineffectual. It is my faith and trust in the child's ability for healthy reemergence which provide the impetus for this confrontation. Studies have shown that children who

experience a death crisis, develop more mature conceptualizations than are attained through development without such a crisis (Bluebond-Langner, 1977; Kane, 1978). Dabrowski (1967) contends that the disintegration of psychic structures, which is characteristic of bereaved children, can lead to psychic and emotional reintegration on a higher level. However, there seem to be few, if any, studies in the current literature which address the affective development of children following their adaptation to the death of a significant other; or the coping and/or problem-solving abilities of children who have endured a death experience. Research in this area would support my working hypothesis of the self-enhancement value of crisis for children. My experience with Karen is consistent with this hypothesis. Allison wrote the following about her in a recent progress report:

> [In the fall after Ricky's death]; Karen, who had had difficulties in school [since grade one], was much *more confident* in herself and her abilities and began *doing quite well* [grades improved from D's and F's to B's and C's] [and now one year later]...Karen has not lost any of her newly found *self confidence*....Both of them [Jeffrey and Karen] are, I think, *more sensitive* to the possibilities of death and what it means than other children their age, but, on the whole, they have left most of the darkness behind them and are busy getting on with their lives. (Coleman, Note 3)

**Professional Guidelines for Helping Children Cope**

The following aspects of PCP are consistent with the literature reviewed in the area of helping bereaved children cope:

1. Play:
   a. assessing the child's level of understanding of death as prerequisite to helping them cope (Formanek, 1975; Kastenbaum & Aisenberg, 1972; Mills et al., 1976; Nagy, 1948);
   b. using "child-like" language which is simple and concrete; learning the child's talk and frame the discussion in his or her language (Ginott, 1961; Ordal, 1981; Piaget, 1973);
   c. giving the child honest explanations of death (Grollman, 1970; Parness, 1975);
   d. comforting the child physically as well as verbally (Ordal, 1981); and,

e. when the child is in the midst of strong emotions allowing him or her to do most of the talking (Ginott, 1961; Hardt, 1979).

2. Confront:
   a. correcting the child's distortions and misperceptions (Grollman, 1970) and addressing possible conflicts of meaning (Kolls, 1976);
   b. sharing personal and ambivalent feelings--"honest uncertainty" Grollman, 1970; Simpson, 1979);
   c. reviewing specific memories (Koocher, 1973; Ordal, 1980);
3. Promote:
   a. emphasizing the continuity of the deceased through memories of shared experiences (Ordal, 1980).
   b. discussing opposites--good-bad, life-death (Gibran, 1963; Ordal, 1980) as continuous entities.

**C. Bereavement Therapy: A Personal Confrontation for the Therapist**

The techniques presented in this thesis are a product of my personality and my relationship with two children in therapy. The transcribed excerpts are more than a demonstration of techniques; they are examples of my "way of being" with bereaved children in therapy. In bereavement therapy, the therapeutic relationship becomes symbiotic and intense and can change the therapist as much as it does the child. Bereavement therapists, therefore, must be both open and willing to change. Religious and philosophical assumptions are challenged, concerns of personal finitude, mortal anxiety and life meaning come to the fore for the therapist working in the area of bereavement. Those who fear confrontation, and wish to avoid challenge and change, should not become bereavement therapists. Reading the related literature and adopting pre-established techniques is useful but not sufficient for working with these children.

## D. Between Adults and Children: Conceptualizations of Life and Death to Share In and Out of Therapy

### The Cyclical Nature of Life and Death

The "death and continuity of life" theme is one I have adopted in helping children to cope with and understand the inevitability of death. To explain that people are born, mature, give birth to children, grow old and die is to express biological fact. But deriving its power from this biological fact, and from the human aspiration for continuous and renewed life, is the universal religious symbolism of death and rebirth:

> In the Jewish expectation of the Messiah who will come and renew the community, in Christ's promise 'to make all things new,' in the Hindu vision of release from the mundane cycle of endless reincarnations--the hope of a new birth is a universal psychic force. (Lifton & Olson, 1974, p. 135).

It has been the underlying philosophical assumption throughout this thesis that it is the enduring and suffering of crisis which prepares the way for the child's psychological growth and development: "The image is of the survivor as creator: the one who has known disintegration, separation and stasis now struggling to achieve a new formulation of self and world" (Lifton & Olson, 1974, p. 137). New formulations can be achieved by the bereaved child who is encouraged to explore his or her feelings and thoughts with a therapist who is willing to risk and guide the child in this journey.

As winter makes its way for spring, and night for the light of day, so too, does crisis pave the way for the experiencing of joy and triumph. These are the images of death and rebirth that find universal expression in the bible, religion, psychology, philosophy, and literature:

> Man saw this [theme] in nature as winter yields to spring in the cycle of the seasons, as children were born in pain, as food was consumed to give life, as saplings sprang from the rotting trunks of dead trees. It seemed that life and death were not opposite poles, miles apart at the extremes of some dichotomy, but rather partners, dancing an eternal cyclical dance together in a dance called the process of the world, the ongoing-ness of the universe. Man has celebrated this cycle in his mysteries and his legends, symbolized by the phoen rising from its ashes (Hague, Note 4)

The natural and cyclical view of life and death is one that can be offered to children in bereavement therapy. It is a view which does not counter, but rather complements, most predominating religious views. Our linear thinking is reflected in our "either/or," dichotomous thinking which is characteristic of children's thinking. We think of "beginning" and "end" as two separate entities, and life and death as opposites. The cyclical thinking of life and death as suggested by Gibran, and the interactional view presented by the existentialists--that death is a part of life and that it is what gives life meaning--seem to be views which are conducive to a more peaceful, natural view of death and to quality living.

My model is cyclical as was its development. The various phases of the model recur during the course of therapy. This thesis, too, is cyclical. The conclusions (ending) give value to the statement of purpose (beginning). The ending gives implications for a new beginning. The thesis can be read beginning at any chapter and continuing through--and in this way serves as a metaphor for life and death.

**Focusing on the "How" Instead of the "Why"**

In therapy as in everyday life we often ask the "why" instead of the "how" when questioning the nature of things. With questions of life and death and their meaning, however, there are no ultimate answers as evidenced by the diversity of existing attempts (through religion, philosophy, servitude to others, for example). If we focus on how we live and how we die, the need to know why will become extraneous. If we concentrate on how it is when we are with others, we will be insured of memories for when they are no longer there; and, in focusing on the "how," we guarantee quality living in the present that will not be the source of regret in the future.

**E. Stages, Phases and Levels**

Lonetto (1981) warns us: "Stages, phases, levels are becoming our archetypal way of dealing with complex human issues. If the problem can be reduced enough, the illusion is created that it is solved" (p. 81). In this thesis I have presented "stages" of the grieving process, "phases" of therapy, and "levels" of children's conceptualizations of death. The compartmentalizing of feelings, thoughts, and the therapeutic process can potentially override the individuality of child and therapist alike. It is important for the therapist to use these stages, phases, and levels as guidelines to be applied creatively and selectively to "individuals" in therapy. Among bereaved children there exists a variety of needs, emotions, thoughts, concerns and defenses. "Schematic stages...are at best approximations, and at worst, obstacles for individualization." (Weisman, 1972, p. 111)

**F. Generalization to Other Types of Loss**

The research presented, the PCP model and its techniques originated from work with bereaved children--children who have lost significant others through death. Loss and separation for these children are permanent. This is not to say that the general attitude and approach presented herein are limited to these children. The open, honest, confrontive approach can be used with any children who have experienced a crisis, and especially those who have suffered a loss.

Loss through separation or divorce of parents and through institutionalization or foster placement of the child, however, are not necessarily permanent, nor do they necessitate separation of the parent from the child. In divorce, for example, separation is between parents and may mean that the child will see one parent on a less regular basis than he or she is used to. Each type of separation or loss creates its own unique problems for the child. In most types of loss other than bereavement, feelings of guilt, anger, fear and rejection can be discussed with the parent taking leave. The bereaved child, however does not have the same opportunity to reconcile the loss. He or she

must do so in a symbolic or spiritual manner.

Children who do not appear to be coping with their changed family situation (foster home, single-parent family) can be helped by the same psychotherapeutic guidelines and approach proposed here. Although PCP originated from work with bereaved children, it is not limited to them.

**G. Limitations**

In the course of this study I have explored what professionals in the area of childhood bereavement have to suggest for helping bereaved children cope and have discovered that my methods are substantiated by what they recommend. Furthermore I have developed some particularly useful methods for helping bereaved children in therapy and have used this thesis as a forum for sharing them. The following are limitations to the study:

1. The main strength of this thesis is also its major limitation. This is largely a theoretical study and further research, in all its meanings, is needed to validate the findings. I have provided the creative impetus and a new direction for researchers in the area. This study has its value by way of example and not by way of proof: "One success is better than multiple failures. One success proves it can be done. What is, is possible." (R. K. Merton)
2. The study involves only two children which presents several limitations. Firstly the ages of the two children fall within the "middle-age" range of childhood. Thus there is no "in vivo" exploration of children at the other cognitive developmental stages. Secondly, the techniques were tailored for these children in particular. Both children were verbally expressive and the methods were adapted accordingly. They appeared to work for these children but must be used flexibly with others. Therapists may add these to their "bag of tricks" and pull them out or adapt them whenever the moment is right. Thirdly, the children are siblings who have had similar explanations given to them and similar life experiences. Having a sibling close in age to share the experience with was probably "therapeutic" in

itself. Fourthly there are several factors which influenced the two children's responses to their loss. Several unique factors compose their "crisis matrix." These include: Roman Catholic religious background; sudden and accidental nature of the death; single-parent family and the fact that they were exposed to one previous and major loss, the loss of their father through divorce.

3. I am the designer of the model, the implementer and the evaluator. This is a strictly subjective study and I recognize that much of what happened is a function of my personality. Therefore, implementation and evaluation of this model by other therapists will lead to new experiences and additional findings.

**H. Implications**

Following are a number of implications for counselling and research in the area of childhood bereavement which arise from the present study.

1. Long-term and qualitative phenomenological research. This study has demonstrated the value of existential therapy as research. Studying the emotional and cognitive "being" and "becoming" of children by actually being with them over time (in therapy, for example) is invaluable.
2. Longitudinal and comparative studies. Most of the existing literature in the area of childhood bereavement has been cross-sectional. Longitudinal research, with the same children over time, and comparative studies, between bereaved and non-bereaved children, would contribute to the body of research in the area of affective and cognitive development of children.
3. Death education for children and adults. The literature suggests the need for early structuring and of death expectations through death education. The open discussing of death in the classroom will give children a forum to express their existential concerns.
4. Courses on grief and death for counsellors. Death and dying are basic to the human condition and should be addressed in counsellor education programs. The counsellor should be prepared to deal with clients who

incur a loss in the course of therapy (loss of a loved one separation and/or death) or during childhoood. Unresolved grief in childhood may be affecting a client's current functioning and fixating his or her psychological and emotional development.

5. Incorporation of theoretical death literature into existing models of child development and psychopathology. There have been some attempts to incorporate the death attitude literature into Piagetian theory. Otherwise, there do not seem to be any attempts to integrate the death literature with existing developmental theories and research.

**Concluding Statement**

I believe that death experiences are opportunities for promoting a child's ability to endow life with more and deeper meaning. The childhood bereavement research and my experience with bereaved children in therapy indicate that giving full credence to the seriousness of the bereaved child's predicament, while communicating faith, trust and acceptance, the therapist enables the child to develop self-confidence and hope for the future.

The child, who is having serious difficulty in adjusting to the death of a significant other, must be helped by the therapist to make some sense out of his or her turmoil of feelings in order to gain self understanding and awareness. Psychotherapeutic techniques tailored to the individual child's needs, can facilitate the therapeutic process and can provide the child with ideas on how to bring order to this inner chaos. A counsellor should take the child's existential concerns and anxieties very seriously and address them therapeutically: loneliness, the need to be loved, the love of life and the fear of death.

To work with a bereaved child does not require of the counsellor a chronic attitudinal set or personal affect of gloom. On the contrary, empathic sharing of heavy sorrow and grief, which is so basic in working with these children, requires that the therapist be prepared, when appropriate, to view the whole situation with a positive, balanced and bright outlook.

Children need to be aware that they can go on building their lives, even when facing the death of a loved one. The strength and courage with which we meet the vicissitudes of life as adults are built during childhood. Grieving children yearn not only for our sympathy and understanding but for the opportunity to discuss their innermost concerns regarding death. In order not to become victimized by the capricious nature of life, we must start developing our inner resources at an early age, so that our emotions, imagination, and intellect will begin to coalesce as we enter adolescence, and complement each other as we enter into adulthood. As we develop hope and acceptance and reach the final stage of the grieving process, we become stronger and gain sustenance which enables us to cope with and surmount the adversities of life.

Existentialists say that a person develops from the living he or she does. A child, too, develops from the living and not only from the 'playing'. In my search for an effective method for helping children in crisis, it has become evident to me that child psychotherapy is not <u>all</u> play.

I, as a therapist, change through the counselling I do; I continue to change and learn effective techniques for helping children through the more and different counselling I do with them. "Being with" children undergoing crises brings me closer to my own existential concerns. Each opportunity I have to re-encounter and explore my own "being" may not bring me closer to finding ultimate meaning, but it does give me strength and courage to face the vicissitudes of life and provides me with the skill and fervour for helping children face them, too.

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## APPENDIX

[To Ricky From Mom--I Miss You, Come Home]

I

You left in such a hurry
out into the cold
on the wings of orange-yellow flames
imprisoned by a wall of smoke
you escaped burning

strangers
calmly efficient
washed your face
and wrapped you
bye baby bunting
in a white sheet
closed your eyes
then they let me
see you touch you
your hair tangled
curls still wet
cheeks flushed

God bless sleep tight

II

...But Whiter Than White is the Leper

It's 32 below
white snow sparkles

down in the basement
the coffins rise in tiers
six foot black rectangles
wait quietly
red mouths open
brass handles
gleam on polished mohogany
sober solid and expensive
protection

the three baby ones apologetically
shoved aside in the corner
on the left
flat white
tiny pillows carefully centred
on satin-covered foam
white on white
casting black shadows
with the rest

It's getting colder

III

He left
in a tiny coffin
with incense burning Holy
smoke to the rafters
sonorous chants
the organ out of tune

his body
bathed and powdered
soft white skin
glowing in the light
is rotting
maggots tracing pretty patterns
from head to foot
hidden in the dark
protected from the earth

IV

Will you never come home
my littlest one?
truly here
will you never curl up in my lap
and wind my hair
around your finger
like you used to
never again
throw your arms
around my neck
and whisper your secrets
so everyone could hear
before you'd dash off
quicksilver disguised
in a dirty face and tousled hair
eyes dancing with
the mischief on your mind

I miss you come home